MIDD Briefing Paper

ES 4c, 4d
BP: 25, 29, 42, 77, 90, 130
Collaborative School-based Behavioral Health Services for Middle School and High School Students

Existing MIDD Program/Strategy Review ☒ MIDD I Strategy Number 4c & 4d (Attach MIDD I pages)
New Concept ☒ (Attach New Concept Form)
Type of category: Existing Program/Strategy EXPANSION

SUMMARY: Current MIDD 4c (Collaborative School Based Mental Health and Substance Abuse Services) strategy invests in prevention/early intervention for school-based services provided in middle schools and MIDD 4d (School Based Suicide Prevention) provides students and schools suicide prevention trainings. This paper proposes to expand the current strategy to include the implementation of the school-based mental health (MH) and substance use disorder (SUD) Prevention Initiative, including investing in school-based substance abuse prevention, mental health promotion, suicide prevention and early intervention services, which includes screening and brief intervention and referral to treatment (SBIRT) services. Part of expansion will include expanding to all middle and high schools in King County to have at least a 1.0 FTE prevention/interventionist /credentialed professional dedicated to the provision of school-based behavioral health prevention/early intervention services. The County will develop and administer a training and technical assistance plan following the RFP process; this may include contracting for trainings in selected evidence based services and related technical assistance and support services.

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The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?

Current MIDD 4c (Collaborative School Based Mental Health and Substance Abuse Services) strategy invests in prevention/early intervention for school-based services provided in middle schools and MIDD 4d (School Based Suicide Prevention) provides students and schools suicide prevention trainings. This paper proposes to expand the current strategy to include the implementation of the school-based mental health (MH) and substance use disorder (SUD) Prevention Initiative, including investing in school-based substance abuse prevention, mental health promotion, suicide prevention and early intervention services, which includes screening and brief intervention and referral to treatment (SBIRT) services. Part of expansion will include expanding to all middle and high schools in King County to have at least a 1.0 FTE prevention/interventionist /credentialed professional dedicated to the provision of school-based behavioral health prevention/early intervention services. The County will develop and administer a training and technical assistance plan following the RFP process; this may include contracting for trainings in selected evidence based services and related technical assistance and support services.

The goals of this revised and expanded concept are to:

- Reduce the risk of students developing mental or emotional illness, or using drugs/alcohol.
- Reduce poor school performance, to prevent school dropout, and to decrease other problem behaviors experienced by youth.
- To build collaboration between organizations in order to connect middle school-aged students or high school-aged students to needed mental health and substance abuse services in the school and community.

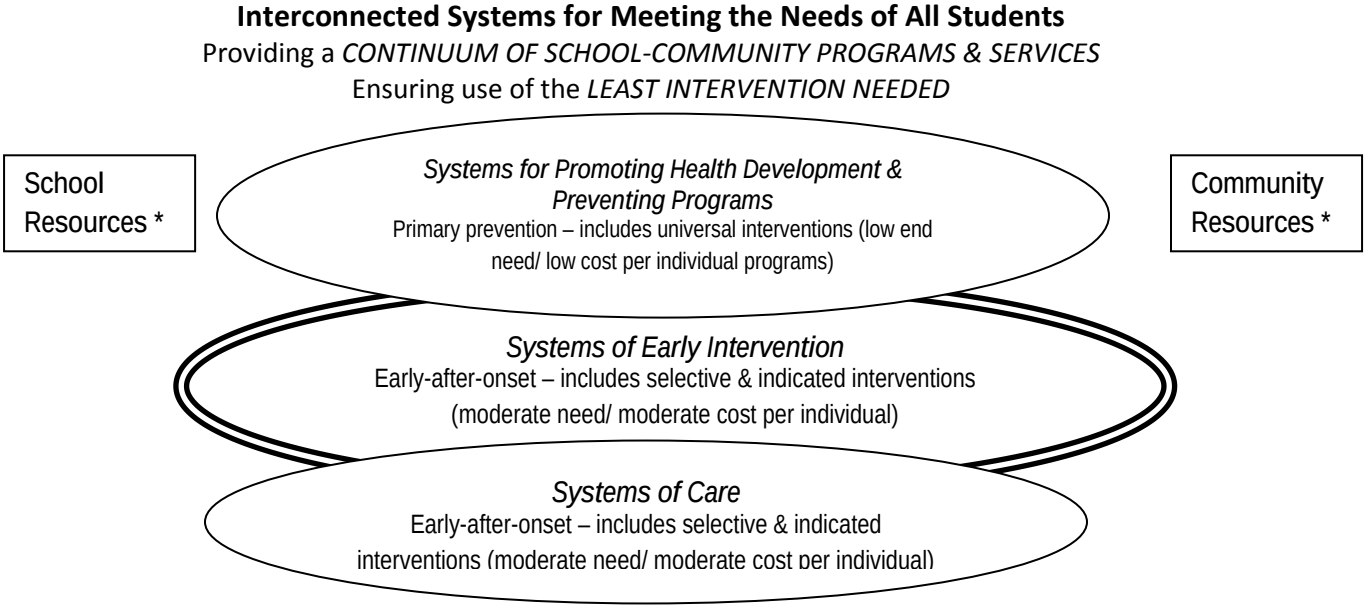
The School-Based MH & SUD Prevention Initiative envisions a multi-component project where schools, behavioral health care providers and communities implement MH & SUD prevention/recovery through intensive training, technical support and infrastructure supporting youth, families, schools and communities in King County. Within the continuum of school-based prevention services to students, the multi-component project will create 'Systems of Early Intervention', providing selective and indicated prevention interventions; some of the initiative components will be universal in scope and fall within primary prevention (Systems for Promoting Health Development & Preventing Programs), in order to ensure that all students are receiving prevention programming.

> **Universal** prevention strategies are designed to reach the entire population, without regard to individual risk factors and are intended to reach a very large audience. The program is provided to everyone in the population, such as a school or community. An example would be universal preventive interventions for substance abuse, which include substance abuse education using school-based curricula for all children within a school district.
> **Selective** prevention strategies target subgroups of the general population that are determined to be at risk for substance abuse. Recipients of selective prevention strategies are known to

have specific risks for substance abuse and are recruited to participate in the prevention effort because of that group's profile.

Indicated prevention interventions identify individuals who are experiencing early signs of substance abuse and other related problem behaviors associated with substance abuse and target them with special programs. The individuals identified at this stage, though experimenting, have not reached the point where clinical diagnosis of substance abuse can be made. Indicated prevention approaches are used for individuals who may or may not be abusing substances who exhibit risk factors such as school failure, interpersonal social problems, delinquency, and other antisocial behaviors, and psychological problems such as depression and suicidal behavior, which increase their chances of developing a drug abuse problem.[1]

Figure 1: Systems of Early Intervention for Prevention: School-Based MH & SUD Prevention Initiative



***Resources include:** facilities, stakeholders, programs and services.

The School-Based MH & SUD Prevention Initiative will be rolled out in phases and include the following components:

- Component 1: Expansion of the current MIDD strategy 4c (Collaborative School-Based Mental Health & Substance Abuse Strategy) to the new School-Based MH & SUD Prevention Initiative, which includes 1.0 FTE per 1,000 students in middle and high school
- Component 2: School-Based Youth Suicide Prevention (including expansion and revamp of current MIDD strategy 4d-School Based Suicide Prevention) to a new integrated zero suicide approach as part of the School-Based MH & SUD Prevention Initiative
- Component 3: Development and integration of school-based SBIRT (screening brief intervention & referral to treatment) initiative county-wide
- Component 4: Development and integration of Trauma-Informed schools initiative county-wide

Component 1: Expansion of the current MIDD strategy 4c (Collaborative School-Based Mental Health & Substance Abuse Strategy) to the new School-Based MH & SUD Prevention Initiative, which includes 1.0

[1] http://www.dshs.state.tx.us/sa/prevention/classifications.shtm

FTE interventionist per 1,000 students in middle schools and high schools. Services will include MH and SUD (behavioral health) prevention and early intervention delivered within the Systems of Early Intervention (Figure 1). The strategy will focus on the following aspects of the continuum of care: selective prevention, indicated prevention, and increasing access to treatment. In addition, the expansion will provide the option for schools to augment their programs and include universal primary prevention programming within their schools (training and technical assistance will be provided for universal prevention program implementation).

Component 2: Expansion of School-Based Youth Suicide Prevention (including expansion and revamp of current MIDD strategy 4d-School Based Suicide Prevention) to a new integrated zero suicide approach as part of the School-Based MH & SUD Prevention Initiative. The strategy will include: suicide awareness/prevention for youth 12-19; social/emotional development training for children and youth; teacher/school personnel suicide prevention training; parent education; and development/implementation of suicide prevention/response policies and procedures. School-Based Youth Suicide Prevention includes adoption of a zero suicide approach and working with schools to adopt Zero Suicide[2] through training and technical assistance. Component 2 includes the following The following seven elements of suicide care for health and behavioral systems that would be adopted through training and technical assistance:

1. Lead – Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles.
2. Train – Develop a competent, confident, and caring workforce. Train all staff commensurate with their potential role in suicide prevention.
3. Identify – Systematically identify and assess (screening and assessment) suicide risk among people receiving care.
4. Engage – Ensure every individual has a pathway to care that is both timely and adequate to meet their needs. Include collaborative safety planning and restriction of lethal means.
5. Treat – Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.
6. Transition – Provide continuous contact and support, especially after acute care. Utilize peers who are in behavioral health recovery who also experience suicidal behaviors to help support those who are at-risk.
7. Improve – Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk. - See more at: http://zerosuicide.sprc.org/about#sthash.3qZWfYEm.dpuf

Component 3: Development and integration of school-based SBIRT (screening brief intervention & referral to treatment)[3] initiative county-wide within the Collaborative School-Based MH & SUD Prevention Initiative. School-based SBIRT will include working with all middle & high schools on the development and implementation of county-wide SBIRT, which includes training and technical assistance in the Global Appraisal of Individual Need - Short Screen (GAIN-SS). The GAIN-SS is a 23-question screening tool that quickly and effectively screens for depression, anxiety, substance abuse, and other behavioral health disorders. The US Preventive Services Task Force (USPSTF) makes recommendations about preventive care services for individuals without recognized signs or symptoms of the target condition. Staff using the GAIN-SS as part of the current MIDD 4c school-based services

[2] http://zerosuicide.sprc.org/
[3] http://www.integration.samhsa.gov/clinical-practice/SBIRT

strategy are able to provide an appropriate brief intervention, follow-up, and as needed, a referral to treatment as part of their prevention/early intervention services.

> What is SBIRT: Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was cited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.[4] The school-based SBIRT, while originally developed for a healthcare setting, has been piloted in King County schools and is a comprehensive public health approach for addressing selected behavioral health concerns.

Component 4: Development and integration of Trauma-Informed Schools[5] initiative county-wide. In trauma-informed schools, the adults in the school community are prepared to recognize and respond to those who have been impacted by traumatic stress. Those adults include administrators, teachers, staff, parents, and law enforcement. In addition, students are provided with clear expectations and communication strategies to guide them through stressful situations. Traumatic situations include; bullying at school, school shootings, divorce, homelessness or dramatic weather events. The goal is to not only provide tools to cope with extreme situations, but to create an underlying culture of respect and support.

Component 5: Integration of evidence-based practices (EBP) into the delivery of all school-based MH and SUD prevention and early intervention services. Infrastructure will be developed and support provided to schools and communities to implement and sustain EBPs. EBPs will be selected from the Blueprints for Healthy Youth Development[6] and the Substance Abuse Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP[7]); both are searchable online registries of MH and SUD prevention evidence-based interventions. A couple of examples of evidence-based practices include screening using the Global Appraisal of Individual Needs Short Screener (GAIN-SS) for SBIRT, Check and Connect[8] and Trauma-Informed Schools.

Note: Six New Concepts were received related to school-based MH & SUD prevention and early intervention and there are two existing MIDD strategies (MIDD 4c[9] and 4d[10]) prompting the briefing paper to include a wider scope within King County for school-based prevention services, incorporating the new concepts and existing strategies, into this new comprehensive approach for King County. Proposed concepts that align with Collaborative School-based Mental Health and Substance Abuse strategy 4c:

- School-Based Mental Health Coordination
- Expanded Prevention and Early Intervention Services for at Risk Youth
- School-based Support Services

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[4] http://www.integration.samhsa.gov/clinical-practice/SBIRT
[5] https://traumaawareschools.org/traumaInSchools
[6] http://www.colorado.edu/cspv/blueprints/
[7] http://nrepp.samhsa.gov/01_landing.aspx
[8] http://checkandconnect.umn.edu/ *Check & Connect* is a comprehensive intervention designed to enhance student engagement at school and with learning for marginalized, disengaged students in grades K-12, through relationship building, problem solving and capacity building, and persistence. A goal of *Check & Connect* is to foster school completion with academic and social competence.
[9] MIDD 4c Collaborative School Based Mental Health and Substance Abuse Services
[10] MIDD 4d School Based Suicide Prevention

Proposed concepts that align with School-based Suicide Prevention strategy 4d

- Student Assistance Program for Trauma Informed Schools
- Check and Connect
- Suicide Safer Schools for King County

The new concept school-based mental health (MH) and substance use disorder (SUD) Prevention Initiative incorporates new concepts and expands upon the existing MIDD into one comprehensive prevention/early intervention plan for school-age youth in King County.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

   ☐ **Crisis Diversion** ☒ **Prevention and Early Intervention**

   ☐ **Recovery and Re-entry** ☒ **System Improvements**

   Please describe the basis for the determination(s).

Prevention and Early Intervention: Collaborative School-based Behavioral Health Services for Middle School and High School Students is an opportunity to use prevention/early intervention to meet the needs of students experiencing MH and SUD issues or who are at risk. By providing school-based services, prevention interventionists and behavioral health counselors are able to address mental health and substance abuse issues that tend to interfere with students' ability to learn, progress in school, and progress along a normal developmental course. This increase in prevention and early intervention by embedding prevention interventionists in the schools will reduce the length of time from identification of an issue of concern to providing the youth with the assistance needed.

System Improvements: Providing more education to providers and community members about Zero Suicide and having a system-wide approach will help reduce stigma among those seeking behavioral health care, foster support for individuals in crisis, and bring more attention and resources to agencies that provide health and behavioral healthcare services.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. **Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

Mental health problems affect 20 percent of the population; about half demonstrate signs and symptoms by the time they are 14 years old, and very few students have access to help. Schools are in the prime position to be first responders and early interveners. Earlier identification and intervention create better prospects for living healthy functioning lives. Substance use continues to be a significant

problem among King County youth. Of those King County students in grade 10 who participated in the 2014 Washington State Healthy Youth Survey, at some time in their lives[11] :

- 31 percent felt depressed
- 18 percent had considered suicide within the past year
- 14 percent made a suicide plan
- 9 percent attempted suicide
- 61.5 percent had tried alcohol
- 26 percent had tried marijuana
- 12 percent self-identify as problem alcohol drinkers
- 17 percent had driven a car after using marijuana
- 14 percent did not safe at school
- 5 percent had carried a weapon to school

Mental health and substance abuse problems in children and youth interfere with their ability to learn, progress in school, and progress along a normal developmental course. A 2001 U.S. Surgeon General report stated that mental health is critical to a child's learning and general health, and is as important as immunizations. Approximately 21 percent of children between the ages nine and 17 have diagnosable emotional or behavior disorders, but fewer than a third receive help.[12] This group of children have an increased risk for dropping out of school and not becoming fully contributing members of adult society.[13] Their difficulties often are not recognized as mental health and/or substance abuse related. They get left behind educationally and socially and can be labeled as difficult, which leads to further isolation from accurate problem identification and professional assistance.

Substance abuse is frequently linked to untreated mental illnesses 43 percent of children who use mental health services also have a substance abuse disorder.[14] There is an increased risk for co-occurring disorders with students who smoke, drink or use other illicit drugs; substance abuse is associated with depression, anxiety disorder, attention deficit hyperactivity disorder, conduct disorder and eating disorders. [15] Children with mental health disorders, particularly depression, are at a higher risk for suicide; an estimated 90 percent of children who commit suicide have a mental health disorder. [16]

Youth who fail at school are much more likely to end up on public assistance and involved in the criminal justice system. According to one study, 66 percent of boys and almost 75 percent of girls in juvenile detention have at least one mental health disorder. [17] A 2005 report from the Civil Rights Project at Harvard University says failure to graduate from high school triples the likelihood of going to jail.

[11] Healthy Youth Survey 2014
[12] *Caring for Kids,* The Center for Health and Health Care in Schools, School of Public Health and Health Services, Graduate School of Education and Human Development, The George Washington University, Summer 2003
[13] U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC: Department of Health and Human Services, 2000
[14] Substance Abuse and Mental Health Services Administration, 2002. Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders
[15] *Malignant Neglect: Substance Abuse and America's Schools,* National Center on Addiction and Substance Abuse, Columbia University, September 2001
[16] U.S. Department of Health and Human Services, *Mental Health: A Report to the Surgeon General,* 1999
[17] President's New Freedom Commission on Mental Health, Final Report to the President, 2003

Schools provide an early opportunity to identify children and youth with mental health and substance abuse problems. School based programs have been shown to improve mental health, and improve educational outcomes and school success.[18] Without proper care, youth problems and challenges compound, so that by the time professional care is offered the mental illness and substance abuse has often progressed to the point that their needs are much more complex; this is why prevention/early intervention strategies are so critical.

2. Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.

With the School-Based MH & SUD Prevention Initiative, King County can expand on current efforts to provide Prevention/Intervention professionals in schools and expand throughout the County in both middle and high schools to address prevention, early intervention and MH, SUD and co-occurring needs among youth. A comprehensive approach will be employed to do the following:

Expand the current MIDD strategy 4c (Collaborative School-Based Mental Health & Substance Abuse Strategy) to the new School-Based MH & SUD Prevention Initiative, which includes 1.0 FTE per 1,000 students in middle and high school. Having prevention/intervention staff onsite will help individual students receive prevention & early interventions services, identify problems before they worsen, receive support during times of crisis, address mental health needs before they become overwhelming, and will focus on attitudes that prevent current and future drug use.

Expand School-Based Youth Suicide Prevention (including expansion and revamp of current MIDD strategy 4d-School Based Suicide Prevention) to a new integrated zero suicide approach as part of the School-Based MH & SUD Prevention Initiative. Suicidal behavior and deaths by suicide are a major public health problem nationally and in King County. Suicide is the second leading cause of death in the State of Washington for youth 10-24 years of age. In Washington State, two youth die by suicide each week; twice as many young people die by suicide than by homicide in Washington State[19]. Without proper care for underlying issues such as depression, substance abuse and mental illness, many King County youth and school staff who suffer from suicidal thoughts (ideation) and suicide attempts utilize emergency rooms and in-patient psychiatric care. Part of the expansion will include assisting schools develop suicide prevention/intervention policies and procedures: Many schools have no policies or procedures to respond to or address suicide. This aspect will help school leadership establish a suicide prevention strategy, to assist staff in identifying students at risk for self-destructive/pre suicide behaviors, and to respond to a suicide crisis if needed. This includes training front line staff such as teachers, nursing staff, coaches and counselors the skills and appropriate steps for intervening with students at risk, engaging families and outside support systems and community resources.

The strategy will also include suicide awareness/prevention for youth 12-19 and gatekeeper training; gatekeeper training for teacher/school personnel training and parent education. Gatekeeper training School-Based Youth Suicide Prevention also includes adoption of a zero suicide approach and working with schools to adopt Zero Suicide[20] through training and technical assistance. The gatekeeper trainings and suicide prevention intervention trainings

[18] *Outcomes of Expanded Mental Health Programs,* Center for School Mental Health Assistance, 2003
[19] http://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/YouthSuicidePrevention/YouthSuicideFacts
[20] http://zerosuicide.sprc.org/

include program such as, Lethal Means Restriction trainings, Applied Suicide Intervention Skills Training (ASIST[21]), Question Persuade Refer (QPR[22]) and Assessing and Managing Suicide Risk (AMSR[23]) King County will develop internal training capacity offer quarterly trainings.

Develop and integrate school-based SBIRT (screening brief intervention & referral to treatment) County-wide within the Collaborative School-Based MH & SUD Prevention Initiative. Prevention intervention professionals use SBIRT and the GAIN-SS, both evidence-based practice tools, when meeting with students. Originally developed for delivery in busy health care settings, SBIRT is an efficient, evidence-based, and comprehensive public health approach for identifying and addressing selected behavioral health concerns such as alcohol/other drug use. SBIRT is readily adapted for delivery in middle and high school settings by pupil services staff as a Tier 2/3 intervention.[24] The GAIN-SS takes approximately three to five minutes to administer and quickly ascertains a student's level of risk for mental health and conduct problems, alcohol/drug involvement, and crime/violence. There is no additional cost after staff are trained to administering the GAIN-SS. Brief Intervention (BI) is protocol-guided and utilizes motivational interviewing, another evidence-based practice, as a communication style to explore and enhance a student's own reasons and motivations for change on a specific "target behavior." BI comprises one to four sessions (approximately 15 minutes each) for students who show moderate to high risk results from screening. BI is an evidence-based practice to address adolescent alcohol/drug involvement and is a promising practice to address a range of other behavioral concerns in the school setting, such as attendance, classroom behavior, fighting, and homework completion. Referral to Treatment (RT) is for students who continue to show significant problem symptoms and who do not respond to the BI. The RT component of SBIRT develops and strengthens linkages between schools and community-based services. SBIRT expands the capacity of student services to address a range of behavioral health concerns; it is student-centered and strengths based. Effective prevention of and intervention with behavioral health problems will likely increase student engagement in school and learning outcomes. [25]

Develop and integrate the Trauma-Informed Schools initiative County-wide. Schools need to know how to respond to student trauma and implement appropriate practices. Children and adolescents who are exposed to traumatic events are helped by numerous child-serving agencies, including health, mental health, education, child welfare, first responder, and criminal justice systems to assist them in their recovery. Service providers, including schools, need to incorporate a trauma-informed perspective in their practices to enhance the quality of care for these children. This includes making sure that children and adolescents are screened for trauma exposure; that service providers use evidence-informed practices; that resources on trauma are available to providers, survivors, and their families; and that there is a continuity of care across service systems. [26]

[21] Applied Suicide Intervention Skills Training (ASIST) is for everyone 16 or older—regardless of prior experience—who wants to be able to provide suicide first aid. https://www.livingworks.net/programs/asist/

[22] Question Persuade Refer (QPR) Three steps anyone can learn to help prevent suicide. https://www.qprinstitute.com/about-qpr

[23] Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals (competence in assessing and managing suicidal patients) http://www.sprc.org/training-institute/amsr

[24] http://www.wishschools.org/resources/schoolsbirt.cfm

[25] http://www.wishschools.org/resources/schoolsbirt.cfm

[26] PsycINFO Database Record (c) 2012 APA

Integrate evidence-based practices (EBP) into the delivery of all school-based MH and SUD prevention and early intervention services. Blueprints for Healthy Youth Development[27] and the Substance Abuse Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP[28]) offer model and promising programs aimed to assist youth with prevention and early intervention. Some EBPs include; Botvin Life Skills Training, Adolescent Coping with Depression, Brief Alcohol Screening and Intervention, Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Good Behavior Game, and Guiding Good Choices.[29]

Several studies have shown that school based services are particularly effective for youth. Adolescents are 21 times more likely to make a mental health visit to a school-based provider than to a community site[30]. The increased availability of MH and SUD prevention and early intervention services in schools reduces the stigma of seeking mental health and SUD care and increases accessibility of that care.

With the School-Based MH & SUD Prevention Initiative, King County can continue to provide prevention intervention professionals in both middle and high schools to address MH, SUD and co-occurring risks with youth. It is clear that support systems that are in place can help youth with making positive decisions regarding the use of alcohol/drugs so that they are able to fully engage in academic completion. Mental health promotion and SUD prevention services are also critical pieces to help youth address depression, anxiety or post-traumatic stress that may be impeding full engagement in their education. Early intervention can help reduce or reverse these risks and change that child's developmental path.

Services will be based on the student population per school district and on school prevention/early intervention needs. The school district will assign a prevention intervention professional to work with students that are referred for either mental health and/or substance use risk and prevention/early intervention as aligned with the School-Based MH & SUD Prevention Initiative. Table 2 lists school enrollments for public middle and high school students in 19 King County districts.

M Middle School; H High School; MH combined Middle High School
Table 1 Student Population by Public School District and Grade

Total Enrollment	M	H	MH	Total
Auburn School District	3229	4982		8211
Bellevue School District	3953	5813	911	10677
Enumclaw School District	902	1396		2298
Federal Way School District	4434	6802	610	11846
Highline School District	2523	5758	316	8597
Issaquah School District	4424	5593		10017
Kent School District	4131	8691		12822
Lake Washington School District	5953	7017	428	13398
Mercer Island School District	1095	1416		2511

[27] http://www.colorado.edu/cspv/blueprints/
[28] http://nrepp.samhsa.gov/01_landing.aspx
[29] http://www.blueprintsprograms.com/programs
[30] The Journal of Adolescent Health. June 2003 Juszczak L, Melinkovich P, Kaplan D

Northshore School District	4584	4682	129	9395
Renton School District	3175	4217	4	7396
Riverview School District	732	999	9	1740
Seattle Public Schools	8613	13355	620	22588
Shoreline School District	1352	2847		4199
Skykomish School District		17		17
Snoqualmie Valley School District	1471	1767	120	3358
Tahoma School District	2482	1820		4302
Tukwila School District	687	918		1605
Vashon Island School District	379	601		980

3. What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide

Research shows that the benefits from middle school prevention programs diminish without follow-up programs in high school[31]. Prevention programs should include teacher training on good classroom management practices, such as opportunities, skills and rewarding appropriate student behavior. Such techniques help to foster students' positive behavior, achievement, academic motivation, and school bonding[32]. Prevention programs are most effective when they employ interactive techniques, such as peer discussion groups and parent role-playing, that allow for active involvement in learning about drug abuse and reinforcing skills[33].

Research-based prevention programs can be cost-effective. Similar to earlier research, recent research shows that for each dollar invested in prevention, a savings of up to $10 in treatment for alcohol or other substance abuse can be realized[34]. Research has shown that the key risk periods for drug abuse occur during major transitions in children's lives. These transitions include significant changes in physical development (for example, puberty) or social situations (such as moving or parents divorcing or changing schools) when children experience heightened vulnerability for problem behaviors[35]. A major transition period for youth is transitioning from elementary to middle school and then from middle school to high school. Part of the transition is social and academic adjustment and dealing with a larger group of peers. It's during these transitions that adolescents are likely to explore drug use. Once youth transition to high school they may be confronted with added social, psychological, and educational challenges. Some of these challenges may involve greater accessibility to drugs and alcohol at social gatherings with their peers.

Risk factors for drug abuse represent challenges to an individual's emotional, social, and academic development. These risk factors can produce different effects, depending on the individual's personality

[31] Scheier et al. 1999
[32] Ialongo et al. 2001
[33] Botvin et al. 1995
[34] Pentz 1998; Hawkins 1999; Aos et al. 2001; Spoth et al. 2002a
[35] National Institute on Drug Abuse 2nd Edition 2003

traits, phase of development, and environment. For instance, many serious risks, such as early aggressive behavior and poor academic achievement, may indicate that a young child is on a negative developmental path headed toward problem behavior. Early intervention, however, can help reduce or reverse these risks and change that child's developmental path[36]. A key goal of prevention is to increase protective factors to outweigh risk factors. The table below describes risk and protective factors used by National Institute on Drug Abuse.

Table 2 provides the risk and protective factors that the School-Based MH & SUD Prevention Initiative is designed to impact and the many domains that youth will touch and the prevention and early intervention services will have influence on.

Table 2: Preventing Drug Use among Children and Adolescents

Risk Factors	Domain	Protective Factors
Early Aggressive Behavior	Individual	Impulse Control
Lack of Parental Supervision	Family	Parental Monitoring
Substance Abuse	Peer	Academic Competence
Drug Availability	School	Antidrug Use Policies
Poverty	Community	Strong Neighborhood Attachment

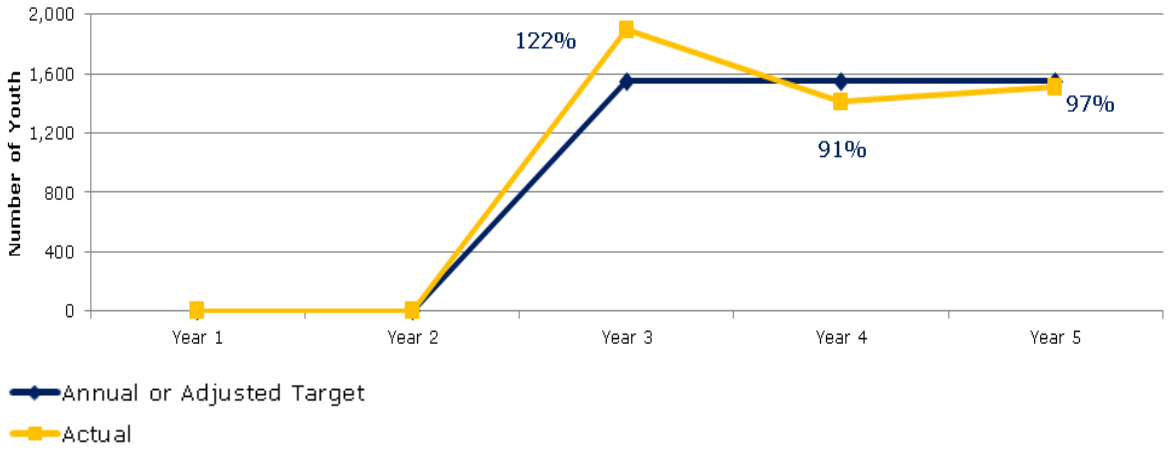
4. **Evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

Current MIDD 4c school-based strategy shows that students have benefited from having a Prevention Intervention professional on-site at middle schools.

Ten agencies provided MIDD 4c services to 21 schools in 11 school districts, employing 13 different program models to deliver tailored services. The average age of youth tracked individually in these school-based programs was 14. A total of 1,510 youth (unduplicated) were served in MIDD Year Five. Large group prevention services, such as school assemblies were provided to another 12,807 youth (not unduplicated).

Outputs (annually) MIDD 4c school-based strategy:

[36] National Institute on Drug Abuse 2nd Edition 2003



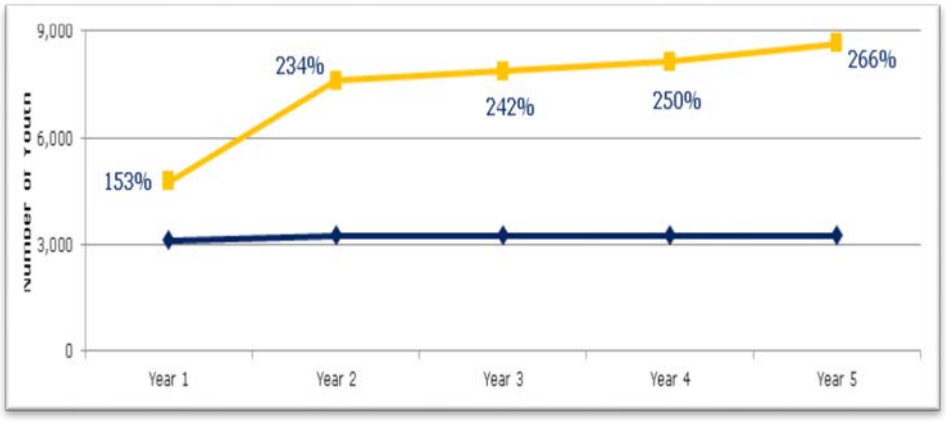
Healthy Youth Survey data indicated that 90 percent of eighth graders did not drink alcohol. Of those who used alcohol, binge drinking was higher on average in 4c schools than in King County, but less than statewide. The statewide incidence for depression was about 25 percent both statewide and in 4c schools. Suicidal thoughts were slightly lower in 4c schools than in King County as a whole. In 4c schools, 69 percent of eighth graders were aware of adults available to help them vs. only 46 percent of the eighth graders in King County.

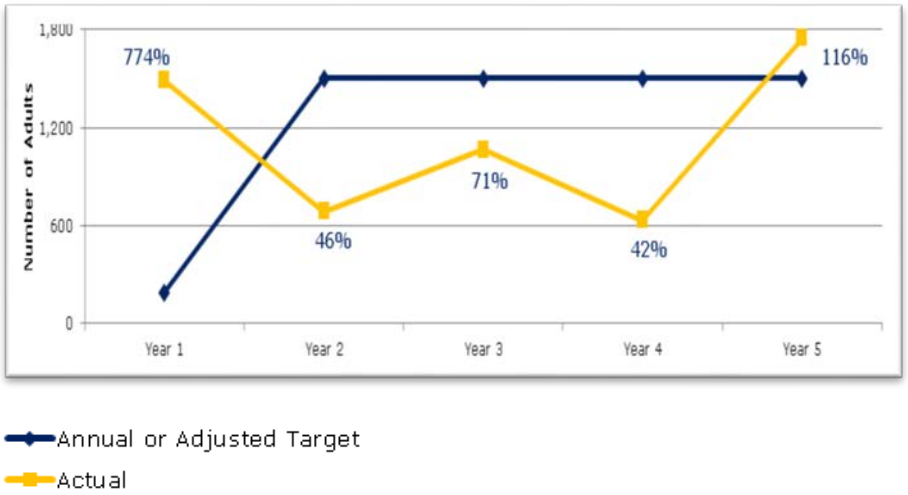
Of 1,043 youth eligible for outcomes, 109 (10%) had initial GAIN-SS data. Sixty percent scored high on depression or anxiety, while only 13 percent had high SUD screens. No data were available for change analysis.

In the 2012 Healthy Youth Survey, approximately 11,600 King County high school students (14% of all students) said they had made a plan to commit suicide within the past 12 months. In an effort to reduce alarming statistics such as these, the MIDD funds the delivery of youth suicide prevention trainings to both school-aged youth and concerned adults throughout the county. Teen trainings offer a safe place to talk openly about suicide, self-harm, depression, concern for friends, and how to ask for and get help. Under this strategy, school districts also have opportunities to improve safety planning and their written crisis response policies.

Total number served (and numbers served annually): For the current reporting period (October 2014-September 2015), the Crisis Clinic's Teen Link program gave 330 youth suicide prevention talks heard by 8,634 students. Teen Link continues to build strong relationships with area schools. The Youth Suicide Prevention Program (YSPP) delivered 69 trainings to 1,746 concerned adults, now available in Spanish also. Blending MIDD funds with funding from other sources has allowed the youth suicide prevention strategy to outperform its annual targets in reaching youth audiences. Population of Focus: King County School students (age 12-19), including alternative school students, school staff and administrators, and students' parents and guardians.

Outcomes (annually) youth suicide prevention strategy:





For the first time since MIDD Year One, the adult component exceeded its goal as well. Of the total number of people trained, 65 percent were high school age, 18 percent were in middle school, and 17 percent were adults.

Combined Suicide/Attempt Rates per 100,000 Youth

	2008	2009	2010	2011
King County	51.4	41.0	46.7	32.8
Statewide	48.2	44.2	44.5	40.5

Source: www.dshs.wa.gov/rda/research/risk.shtm

The State of Washington published a report in 2013 that showed King County's youth suicide rate (completed plus attempted) decreasing at a rate greater than other Washington counties. The table shows completed suicides plus documented attempts per 100,000 youth (aged 10-17) in King County alone vs. statewide between 2008-2011. Attempt data were from hospital admissions and completed suicides were from death certificates.

5. Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Evidence-Based Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.

The school-based mental health (MH) and substance use disorder (SUD) Prevention Initiative is a new/revamped concept for King County.

School based MH & SUD prevention and early intervention services are an important part of the continuum of publicly funded behavioral healthcare services; many components of a comprehensive school-based mental health (MH) and substance use disorder (SUD) Prevention Initiative are evidence-based practice and play an important role in preventing and reducing youth substance use and increasing mental health promotion.

Components of the school-based mental health (MH) and substance use disorder (SUD) Prevention Initiative that are specifically evidence-based practices include screening using the Global Appraisal of Individual Needs Short Screener (GAIN-SS), Check and Connect and Trauma-Informed Schools. Each has merit and research has shown the effectiveness of each. Prevention Intervention professionals use SBIRT and GAIN-SS, both evidence based practice tools, when meeting with students. Both SBIRT and the GAIN-SS have been described above.

Check and Connect is a comprehensive prevention program for marginalized, disengaged students in grades K-12 that is designed to enhance student engagement at school and with learning through relationship building, problem solving and capacity building, and persistence. A goal of Check and Connect is to foster school completion with academic, emotional and social competence. The program pairs struggling middle school students who are at risk for mental health and substance abuse issues with monitors/counselors who helps aid the student to increase skills in problem-solving, behavioral health and academic success. Building these skills is essential in the prevention for substance abuse and mental illness for King County youth.

In trauma-informed schools, the adults in the school community are prepared to recognize and respond to those who have been impacted by traumatic stress. Those adults include administrators, teachers, staff, parents, and law enforcement. In addition, clear expectations and communication strategies are provided to students to guide them through stressful situations. Traumatic situations include, bullying at school, school shootings, divorce, homelessness or dramatic weather events. Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is an evidence-based practice (EBP) that is often used in school settings. The goal of CBITS is not only to provide tools to cope with extreme situations, but also to create an underlying culture of respect and support. A 10-session group intervention is provided by mental health professionals to reduce children's post-traumatic stress disorder (PTSD), depression and anxiety resulting from exposure to violence. Also included are one to three individual child sessions, two optional parent sessions, and a teacher educational session.

Most theories that describe adolescent problem behavior incorporate the role of the school in an adolescent's life. For example, Catalano and Hawkins' social development model stresses the importance of school bonding as a critical component of pro-social development[37]. Students who are not well bonded to school are more likely to follow an anti-social path through adolescence. As students

[37] Journal of Social Health September 2004. Vol. 74. No. 7

become disengaged from school, one potential manifestation of this disengagement may be truancy, and the social development model would suggest that disengaged students are more likely to become involved with drug use. Reaching truant youth before they become more seriously involved in drug use and other delinquent behavior provides an excellent opportunity to reduce the likelihood they will move into the juvenile justice system.

The additional phases of the school-based mental health (MH) and substance use disorder (SUD) Prevention Initiative will use other evidence-based programs from the Blueprints for Healthy Youth Development[38] and the Substance Abuse Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP[39]).

6. What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?

An important goal of prevention/early intervention, then, is to change the balance between risk and protective factors so that protective factors outweigh risk factors. Often, families that are meeting the youth's emotional, cognitive and social needs serve as protective factors. Studies have shown that children with poor academic performance and inappropriate social behavior at ages seven to nine are more likely to be involved with substance abuse by age 14 or 15.

The school-based mental health (MH) and substance use disorder (SUD) Prevention Initiative proposes the following outcomes:

- Increased number of school-community collaborations
- Improved school performance
- Improved school attendance
- Decrease in suspensions and other disciplinary actions
- Decrease in truancy petitions filed
- Decrease in juvenile justice involvement
- # of effective, evidence-based prevention interventions implemented
- Decrease in drop-out rates

C. Populations, Geography, and Collaborations & Partnerships

1. What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program: (Select all that apply):

- ☐ **All children/youth 18 or under**
- ☐ **Children 0-5**
- ☒ **Children 6-12**
- ☒ **Teens 13-18**
- ☐ **Transition age youth 18-25**
- ☐ **Adults**
- ☒ **Racial-Ethnic minority (any)**
- ☒ **Black/African-American**
- ☒ **Hispanic/Latino**
- ☒ **Asian/Pacific Islander**
- ☒ **First Nations/American Indian/Native American**
- ☒ **Immigrant/Refugee**

[38] http://www.colorado.edu/cspv/blueprints/
[39] http://nrepp.samhsa.gov/01_landing.aspx

- ☐ **Older Adults**
- ☒ **Families**
- ☐ **Anyone**
- ☐ **Offenders/Ex-offenders/Justice-involved**
- ☐ **Other – Please Specify:**
- ☐ **Veteran/US Military**
- ☒ **Homeless**
- ☒ **GLBT**
- ☐ **Women**

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

The target population is students attending public, private and charter schools within King County, specifically, either middle school-aged students or high school-aged students. Middle school/high, school present as opportune times to offer targeted interventions to students who have not yet become system involved, but are presenting risk factors that may lead to mental health concerns, substance abuse, involvement in the justice system, and/or poor school performance or drop-out.

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

This strategy would be working with middle and high schools throughout King County. Partnerships would be formed between schools and community agencies as part of the RFP process; this may include contracting for trainings in selected evidence-based prevention and early intervention services and related technical assistance that would provide a prevention/early intervention services in the middle and high schools. The school-based mental health (MH) and substance use disorder (SUD) Prevention Initiative is low barrier, youth/person centered, and strength based focused; there is no cost to participants; there are few transportation issues, as services are provided in the school. The program is confidential, and many times even reluctant students are willing to try it. It provides King County students with an easy access opportunity to address issues -with a problem solving approach.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

Partnership with school districts and schools; Seattle and King County Public Health; Community Services Division; King County Behavioral Health Integration , school-based health clinics; education services districts, behavioral health providers, parents, youth/students, and other community providers.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

The Affordable Care Act increases the number of those eligible for behavioral health services, making it easier to access publicly funded treatment for those students identified as needing a higher level of care. A shift in political priorities to push interventions upstream and avoid costly service intensive interventions requires dedicating resources to prevention and early intervention, which have been proven to be cost effective.

2. **What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

A barrier that may exist to implementation is the unwillingness of some schools to have prevention/intervention professionals in their schools, or to create programs to address behavioral health issues in the school setting. This could be overcome through community outreach and forming relationships. Motivational interviewing type discussions can be held with school administrators and faculty to identify how, and developing individualized programs within each school, together with the school principals and their teams.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

Unintended consequences include competition for limited in-school resources, such as space. Some school staff could be resentful or ambivalent about using classroom time for generalized prevention programming rather than academics. It is possible that students seen meeting with the prevention intervention specialist could be stigmatized. Also, it is possible that a greater level of trauma or numbers of high risk students than anticipated could be identified, over and above what the school can effectively manage.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

If the School-Based MH & SUD Prevention Initiative is not implemented, the alarming trend of suicidal ideation, suicide attempts, and successful suicides among youth will continue, as well as trajectories toward substance abuse and its negative consequences, such as school drop-out and criminal justice involvement, that can lead to dire outcomes, such as homelessness and premature death.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD**

Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?

The School-Based MH & SUD Prevention Initiative currently exists partially in MIDD 4c and MIDD 4d (collaborative school based MH and SUD services and youth suicide prevention services). Seattle King County Public Health currently provides School-Based health centers, but the centers do not include an MH/SUD prevention/early intervention component. Lastly, the Division of Behavioral Health and Recovery (DBHR) provides funding for four communities in King County under the Community Prevention Wellness Initiative for prevention coalitions that include a prevention interventionist cited at a local school; this project is in partnership with King County and the Puget Sound Educational Services District (PSESD).

The School-Based MH & SUD Prevention Initiative proposal is comprehensive and is a true prevention/early intervention approach to school-based MH & SUD school-based services as it is county-wide and ensures that all students are equally receiving prevention and early intervention services, therefore having the same availability of services to all youth in the county.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

Prevention and early intervention services occur early in the continuum of care, providing upstream solutions prior to problem escalation and need for intensive treatment and costly interventions. They are part of Behavioral Health Integration, Best Starts for Kids, Zero Suicide Initiative and Youth Action Plan. Goals of the MIDD II strategy area of prevention and early intervention are to keep people healthy and stop problems before they start or preventing problems from escalating. Middle and high schools present opportune times and locations to provide prevention and early intervention services early on, which in essence helps decrease escalation of mental health and substance abuse problems.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

The School-Based MH & SUD Prevention Initiative addresses both principles of recovery and resiliency. This strategy is rooted in the understanding that problem behaviors are not the result of children/youth being "bad," but are adaptive responses to things that have happened in their lives and the emotional impact those things have had. This is basic to trauma-informed care. Youth that use positive coping mechanisms and protective factors to recover from substance abuse or mental health issues demonstrate resiliency. Helping students identify and act on personal goals, engage with school, improve academic performance, reduce problem behaviors, reduce/stop substance use, and engage in pro-social behaviors and relationship building are consistent with recovery principles. As described above, this strategy employs evidence-based trauma-informed models of intervention, as determined by SAMHSA and others.

3. How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?

The School-Based MH & SUD Prevention Initiative aligns with equity and social justice by addressing racial and ethnic disparities in behavioral health conditions and school outcomes that many students of color experience. Race and ethnicity should not be a barrier for students to succeed at an academic or social/emotional level. By addressing equity and social justice, schools can be more involved to address disparities and level the playing field to improve academic outcomes and decrease dropout rates for students of color. By developing and implementing a prevention/intervention strategy that is truly County-wide, all King County youth, regardless of race, ethnicity, school district or family wealth, where they live, etc., will have equal access to prevention/early intervention, which in turn reduces risk and increases protection.

F. Implementation Factors

1. What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program (staff, physical space, training, UA kits, etc.)**?**

Staff will be needed to develop and implement a training and technical assistance plan to support the implementation of evidence-based school-based behavioral health prevention and intervention practices. Staff resources for each school, along with attendant laptops, phones, workspace, etc. will be needed. Space, and potentially backfill resources will be needed for trainings.

2. Estimated ANNUAL COST. More than $5 million Provide unit or other specific costs if known.

The School-Based MH & SUD Prevention Initiative briefing paper incorporates six new concepts and two existing strategies and has five components to create an overarching initiative for school based prevention/early intervention services for King County.

The estimated biennial budget for funding of these combined new concepts and existing MIDD I strategy is as follows:

Component 1: School-Based MH & SUD Prevention Initiative,		
which includes 1.0 FTE per 1,000 students in middle and high school		$12,172,000
OR Partial implementation 1.0 FTE per 1,500 students		*$8,111,720*
Component 2: Expansion of School-Based Youth Suicide Prevention		$300,000
Component 3: School-based SBIRT (partners with Component 1) training/TA and GAIN online tool system		$100,000
Component 4: Trauma Informed Schools training/TA (partners with Component 1)		$100,000
Component 5: EBPs training/TA (may include purchasing training and EBPs)		$200,000
Program management and ongoing training/technical assistance		$200,000
School-Based MH & SUD Prevention Initiative	Total:	$13,072,000
	or	$9,001,720 (partial)

The above information details the costs and cost per unit. Table 3 below provides a summary of costs. In brief, the estimate per FTE used is $85,000 annual cost. Internal costs for administration of the program

have not been determined. It is noted that this is significant body of work involving both frequent contact with provider agencies and school district and school personnel.

The 2015-2016 MIDD budget for strategies 4c and 4d is $2,971,931; annual budget is $1,485,965.

Table 3 Summary of Implementation Costs

FTEs for Full Implementation **Middle School**	Estimated Costs for Full Implementation Middle School (per 1,000 students)	Estimated Costs for Partial Implementation Middle School (per 1,500 students)
64.5	$5,482,500	$3,652,563
Needed FTE for Full Implementation **High School**	Estimated Costs Full Implementation High School (per 1,000 students)	Estimated Costs Partial Implementation High School (per 1,500 students)
78.7	$6,689,500	$4,459,157
TOTALS	$12,172,000	$8,111,720

Note: School districts will be phased in over time as not all schools will be ready to embrace all components of this proposed strategy right away and staff will only be able engage in intensive start-up activities with a limited number of districts at a time, beginning with schools that already have resources from MIDD I. See question 3 below for phase-in timeline.

2. Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.

Revenues from Best Start for Kids may be able to be used in conjunction with MIDD funds.

3. TIME to implementation: At least a year from award

a. What are the factors in the time to implementation assessment?

Expanding the current MIDD 4c and 4d programs will improve coverage in the 11 school districts where MIDD I provides services now. This can be accomplished in the first 12 months, with a goal of having program staff at all the middle schools in each of the 11 districts. The program, with accompanying staff, should be expanded to all 19 districts in year two. Staff should be provided and the program implemented at the high schools in 10 districts by the end of year three, with full implementation by the end of year four.

b. What are the steps needed for implementation?

The follow are some of the steps needed for implementation:

1. Hiring BHRD staff
2. RFP process
3. Planning for year one implementation
4. Discussions with each school district administration
5. Development of a data driven model of service needs for each school district
6. Development and determination of the EBP to be initiated at the schools to be included (note: this may vary from school to school and will depend on need as informed by data and capacity at the school, including space issues)
7. The schools may need to inform parents/caregivers about the program
8. Determining need and hiring county staff
9. Contracting with the agencies for the 2017-2018 period
10. Hiring staff at the agency
11. Training agency staff on the EBPs to be used
12. Development of an evaluation plan including data collection
13. Review and analyses of implementation
14. Planning for subsequent years' implementation

c. Does this need an RFP?

Yes, an RFP will be needed.

Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

Strategy Title: Invest in Prevention and Early Intervention

Strategy No: 4c – School District Based Mental Health and Substance Abuse Services

County Policy Goal Addressed:

- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

◊ *A. Problem or Need Addressed by the Strategy*

Mental health and substance abuse problems in children and youth interfere with their ability to learn, progress in school, and progress along a normal developmental course. A 2001 U.S. Surgeon General report stated that mental health is critical to a child's learning and general health, and is as important as immunizations. Approximately 21 percent of children between the ages 9 and 17 have diagnosable emotional or behavior disorders, but fewer than a third receive help.[40] This group of children has an increased risk for dropping

[40] *Caring for Kids,* The Center for Health and Health Care in Schools, School of Public Health and Health Services, Graduate School of Education and Human Development, The George Washington University, Summer 2003

out of school and not becoming fully contributing members of adult society.[41] Their difficulties often are not recognized as mental health and/or substance abuse related. They get left behind educationally and socially and can be labeled as difficult, which leads to further isolation from accurate problem identification and professional assistance.

Substance abuse can be linked to untreated mental illness as 43% of children who use mental health services also have a substance abuse disorder. [42] There is an increased risk for co-occurring disorders with students who smoke, drink or use other illicit drugs; substance abuse is associated with depression, anxiety disorder, attention deficit hyperactivity disorder, conduct disorder and eating disorders. [43] Children with mental disorders, particularly depression, are at a higher risk for suicide; an estimated 90% of children who commit suicide have a mental disorder. [44]
Youth who fail at school are much more likely to end up on public assistance and involved in the criminal justice system. According to one study, 66% of boys and almost 75% of girls in juvenile detention have at least one mental disorder. [45] A 2005

report from the Civil Rights Project at Harvard University says failure to graduate from high school triples the likelihood of going to jail.

Without proper care their problems and challenges compound so that when professional care is offered the mental illness and substance abuse has progressed to the point that their needs are much more complex.

◊ *B. Reason for Inclusion of the Strategy*

Schools provide an early opportunity to identify children and youth with mental health and substance abuse problems. School based programs have been shown to improve mental health, and improve educational outcomes and school success.[46]

◊ *C. Service Components/Design*

Due to the complex nature of the project, the number of potential partners and the implementation development timeline, the service design work for this strategy has not been completed. Services design will be defined with local partners with services delivery to begin with 2009/2010 school year.

◊ *D. Target Population*

[41] U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC: Department of Health and Human Services, 2000
[42] Substance Abuse and Mental Health Services Administration, 2002. Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders
[43] *Malignant Neglect: Substance Abuse and America's Schools,* National Center on Addiction and Substance Abuse, Columbia University, September 2001
[44] U.S. Department of Health and Human Services, *Mental Health: A Report to the Surgeon General,* 1999
[45] President's New Freedom Commission on Mental Health, Final Report to the President, 2003
[46] *Outcomes of Expanded Mental Health Programs,* Center for School Mental Health Assistance, 2003

Children and youth enrolled in King County schools who are at risk for future school dropout.

◊ *E. Program Goal*

To reduce the risk of students developing mental or emotional illness, or using drugs/alcohol.

◊ *F. Outputs/Outcomes*

Up to 19 competitive grant awards to schools, school districts, or community-based organizations in partnership to provide a continuum of mental health and substance abuse services in schools, with a focus on those youth identified as most at risk for dropping out of school and becoming involved in the juvenile justice system.

Using an existing model of in-school services in the Seattle school-based health centers, it is estimated that each school-based counselor would provide therapeutic interventions with five students per school day, in addition to providing facilitation of group activities and school-wide initiatives including population-based mental health preventive and mental health promotion strategies. Counselors would coordinate with MIDD Strategy 4d School Based Suicide Prevention activities and programs, therefore counselors may also be deployed to other schools in their district to assist in the event of a significant event or tragedy such as the suicide, death, or serious assault of a student, teacher, or other school staff.

Expected outcomes:

- Reduced risk of students developing mental and emotional illnesses and abusing drugs and alcohol.
- Improved school performance and reduced involvement in juvenile justice and emergency medical systems.

2. Funding Resources Needed and Spending Plan

The program needs $1,235,306 of MIDD fund per year to sustain.

Dates	Activity	Funding
April-December 2008	Stakeholder planning process	$0
	Total Funds 2008	**$0**
January-June 2009	Complete planning, develop and issue Request for Proposals (RFPs)	$0
June-August 2009	Select recipients, complete contracts, staff hired	$125,000
September-December 2009	Services begin	$400,000
	Total Funds 2009	**$ 525,000**

2010	Services fully operational	$1,235,000
Ongoing Annual	**Total Funds**	**$1,235,000**

3. Provider Resources Needed (number and specialty/type)

◊ *A. Number and type of Providers (and where possible FTE capacity added via this strategy)*

To be determined through the planning process.

◊ *B. Staff Resource Develop Plan and Timeline (e.g. training needs, etc.)*

To be determined through the planning process.

Dates:	Activity:
April – December 2008	Planning Process
June – August 2009	Staff Training

◊ *C. Partnership/Linkages*

Public Health; Community Services Division; King County Systems Integration Initiative, school-based health clinics; local schools and school districts, education services districts, mental health providers serving children of active duty military

personnel, and other community providers. Linkage to MIDD strategy 4d School Based Suicide Prevention.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

To be determined in the planning process

◊ *B. Procurement of Providers*

May-June 2009

◊ *C. Contracting of Services*

August 2009

◊ *D. Services Start Date(s)*

School year 2009-2010

Strategy Title: Invest in Prevention and Early Intervention

Strategy No: 4c – Collaborative School ~~District~~ Based Mental Health and Substance Abuse Services

County Policy Goal Addressed:

- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

◊ *A. Problem or Need Addressed by the Strategy*

Mental health and substance abuse problems in children and youth interfere with their ability to learn, progress in school, and progress along a normal developmental course. A 2001 U.S. Surgeon General report stated that mental health is critical to a child's learning and general health, and is as important as immunizations. Approximately 21% of children between the ages 9 and 17 have diagnosable emotional or behavior disorders, but fewer than a third receive help.[47] This group of children have an increased risk for dropping out of school and not becoming fully contributing members of adult society.[48] Their difficulties often are not recognized as mental health and/or substance abuse related. They get left behind educationally and socially and can be labeled as difficult, which leads to further isolation from accurate problem identification and professional assistance.

Substance abuse can be linked to untreated mental illness as 43% of children who use mental health services also have a substance abuse disorder. [49] There is an increased risk for co-occurring disorders with students who smoke, drink or use other illicit drugs; substance abuse is associated with depression, anxiety disorder, attention deficit hyperactivity disorder, conduct disorder and eating disorders. [50] Children with mental disorders, particularly depression, are at a higher risk for suicide; an estimated 90% of children who commit suicide have a mental disorder. [51] Youth who fail at school are much more likely to end up on public assistance and involved in the criminal justice system. According to one study, 66% of boys and almost 75% of girls in juvenile detention have at least one mental disorder. [52] A 2005 report from the Civil Rights Project at Harvard University says failure to graduate from high school triples the likelihood of going to jail.

[47] *Caring for Kids,* The Center for Health and Health Care in Schools, School of Public Health and Health Services, Graduate School of Education and Human Development, The George Washington University, Summer 2003

[48] U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC: Department of Health and Human Services, 2000

[49] Substance Abuse and Mental Health Services Administration, 2002. Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders

[50] *Malignant Neglect: Substance Abuse and America's Schools,* National Center on Addiction and Substance Abuse, Columbia University, September 2001

[51] U.S. Department of Health and Human Services, *Mental Health: A Report to the Surgeon General,* 1999

[52] President's New Freedom Commission on Mental Health, Final Report to the President, 2003

Without proper care their problems and challenges compound so that when professional care is offered the mental illness and substance abuse has progressed to the point that their needs are much more complex.

◊ *B. Reason for Inclusion of the Strategy*

Schools provide an early opportunity to identify children and youth with mental health and substance abuse problems. School based programs have been shown to improve mental health, and improve educational outcomes and school success.[53]

◊ *C. Service Components/Design*

Due to the complex nature of the project, the number of potential partners and the implementation development timeline, the service design work for this strategy has not been completed. Services design will be defined with local partners with services delivery to begin with 2009/2010 school year.

◊ *D. Target Population*

~~Children and youth enrolled in King County schools who are at risk for future school drop-out.~~
Students attending public and private schools within King County, specifically, depending upon the school district and area, either middle school-aged students or junior high school-aged students.
Middle school/junior high school presents as an opportune time to offer targeted interventions to students who have not yet become system involved but are presenting risk factors that may lead to mental health concerns, substance abuse, involvement in the justice system, and/or poor school performance or drop-out. These grade levels also align with the critical developmental stage of early adolescence – an important time to mitigate risk and promote protective factors in youth.

◊ *E. Program Goals*

~~To reduce the risk of students developing mental or emotional illness, or using drugs/alcohol.~~
The goals of this strategy are:

- To reduce the risk of students developing mental or emotional illness, or using drugs/alcohol.
- To reduce poor school performance, to prevent school drop-out, and to decrease other problem behaviors experienced by youth.
- To build collaboration between organizations in order to connect middle school-aged students or junior high school-aged students to needed mental health and substance abuse services in the school and community.
- To further the development of a comprehensive, integrated Recovery Oriented System of Care.

◊ *F. Outputs/Outcomes*

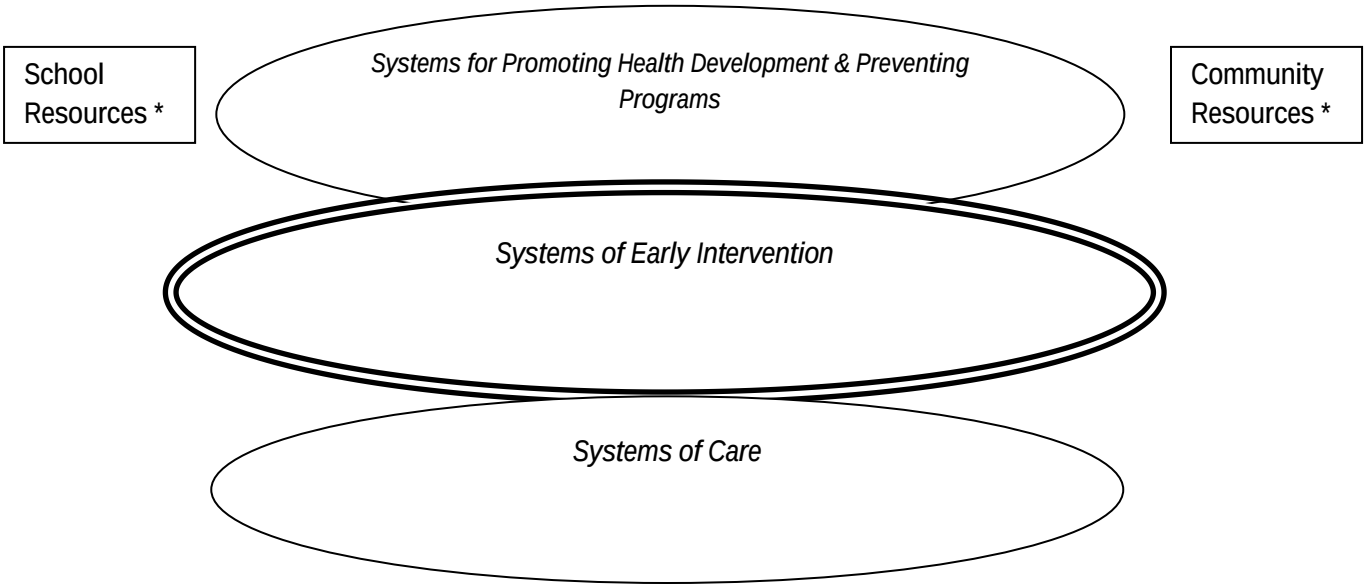
[53] *Outcomes of Expanded Mental Health Programs,* Center for School Mental Health Assistance, 2003

~~Up to 19~~ Competitive grant awards to schools, school districts, or community-based organizations in partnership to provide a continuum of mental health and substance abuse services in schools, with a focus on those youth identified as high risk for substance abuse, mental illness, school dropout and becoming involved in the juvenile justice system. Services will be ~~c~~oordinated with MIDD Strategy 4d School Based Suicide Prevention activities and programs

~~Using an existing model of in-school services in the Seattle school-based health centers, it is estimated that each school-based counselor would provide therapeutic interventions with five students per school day, in addition to providing facilitation of group activities and school-wide initiatives including population-based mental health preventive and mental health promotion strategies. Counselors~~. ~~therefore counselors staff may also be deployed to other schools in their district to assist in the event of a significant event or tragedy such as the suicide, death, or serious assault of a student, teacher, or other school staff.~~

This strategy fits with elements of the report, *Another Initiative? Where Does it Fit? A Unifying Framework and an Integrated Infrastructure for Schools to Address Barriers to Learning and Promote Healthy Development* which includes the following basic components:

Interconnected Systems for Meeting the Needs of All Students
Providing a *CONTINUUM OF SCHOOL-COMMUNITY PROGRAMS & SERVICES*
Ensuring use of the *LEAST INTERVENTION NEEDED*



*** Resources include:** facilities, stakeholders, programs and services.

Expected outcomes:

- Reduced risk of students developing mental and emotional illnesses and abusing drugs and alcohol.
- Improved school performance and reduced involvement in juvenile justice and emergency medical systems.
- Improved school performance for XX% of youth served
- Improved school attendance for XX% of youth served
- Decrease in truancy petitions filed for XX% of youth served

- Decrease in juvenile justice involvement for XX% of youth served
- Decrease use of emergency medical system for XX% of youth served
- Decrease use of psychiatric hospitalization for XX% of youth served

2. Funding Resources Needed and Spending Plan

The program needs $1,235,000 of MIDD fund per year to sustain.

Dates	Activity	Funding
2008 - 2009	Stakeholder planning process	$0
November – December 2009	Develop Request for Proposals (RFP)	
	Total Funds 2008 & 2009	**$0**
January 2010	Issue RFPs	$0
March - August 2010	Select recipients, complete contracts, staff hired, start up, training and technical assistance	$425,000
September-December 2010	Services begin for 2011 school year	$500,000
	Total Funds 2010	**$ 925,000**
2011	Services fully operational	$1,235,000
Ongoing Annual	**Total Funds**	**$1,235,000**

3. Provider Resources Needed (number and specialty/type)

◊ *A. Number and type of Providers (and where possible FTE capacity added via this strategy)*

~~To be determined through the planning process.~~

Dates:	Number of Providers:	Activity:
March – April 2010	TBD (following RFP process)	• Providers will include a partnership between the school, school district and community based substance abuse and/or mental health provider. • RFPs awarded.
April – August 2010		• Contracts negotiated. • Schools hiring at least 1.0 FTE to support strategy services, depending on need, 1.0 FTE may be hired to coordinate strategy implementation, training and technical assistance. • Development and implementation of training and technical assistance plan to support the implementation of evidence based school-based practices.

◊ *B. Staff Resource Development Plan and Timeline (e.g. training needs, etc.)*

~~To be determined through the planning process.~~

Dates:	Activity:
May – June 2010	• Development and implementation of training and technical assistance plan (may include hiring an FTE) to support the implementation of evidence based school-based practices. • Develop program evaluation plan specific to proposals.
June – August 2010	• Provide training and technical assistance per plan to support start up and readiness.
2011 and ongoing	• Program evaluation and modifications will help determine ongoing training and technical assistance needs. • Ongoing training and technical assistance implemented to assure programs achieve goal(s).

◊ *C. Partnership/Linkages*

Public Health; Community Services Division; King County Systems Integration Initiative, school-based health clinics; local schools and school districts, education services districts, mental health providers serving children of active duty military personnel, and other community providers. Linkage to MIDD strategy 4d School Based Suicide Prevention.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

~~To be determined in the planning process~~
Planning for MIDD 4c began with three interdepartmental planning meetings held on July 7, July 30 and August 25, 2008. Staff represented: (1) the King County Department of Community and Human Services (Mental Health, Chemical Abuse and Dependency Services Division); and (2) Public Health-Seattle and King County (Community & School-Based Partnerships).
An expanded planning group was convened and included MIDD Oversight Committee members/representatives and community stakeholders. The following meetings and site visits were conducted:

- September 15, 2008 – Meeting
- October 10, 2008 – Site Visit to Madison Middle School, Middle School Wellness Center
- October 13, 2008 – Meeting
- October 27, 2008 – Site Visit to Kent Phoenix Academy

- November 17, 2008 – Meeting
- January 26, 2009 – Meeting
- May 4, 2009 – Meeting

◊ *B. Procurement of Providers*

~~May-June 2009~~
January – March 2010

◊ *C. Contracting of Services*

~~August 2009~~
March – April 2010

◊ *D. Services Start Date(s)*

Start up April – August 2010

~~School year~~ ~~2009-2010~~
Services begin School year 2010-2011

Strategy Title: Invest in Prevention and Early Intervention

Strategy No: 4d – School Based Suicide Prevention

County Policy Goals Addressed:

- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

◊ *A. Problem or Need Addressed by the Strategy*

Suicide is the second leading cause of death for Washington youth ages 15-24. Between 2000 - 2004, 117 youth in King County died by suicide. In this same period, there were 1,024 hospitalizations of King County youth because of suicidal attempts. Among 10th grade students in King County who responded to the 2006 Healthy Youth Survey, 13 percent reported seriously considering suicide and almost 10 percent reported making a plan within the past 12 months for committing suicide. Between three and four percent reported attempting suicide in the prior year.

◊ *B. Reason for Inclusion of the Strategy*

Currently there is no integrated suicide prevention strategy countywide. Provision of these services will reduce the number of youth suicides in King County. This strategy will also increase the ability of parents, as well as school staff and administrators, to identify warning signs of potential suicide and develop appropriate prevention and intervention strategies.

◊ *C. Service Components/Design*

There are four main components to this strategy:

1. **Suicide awareness presentations for youth 12-19:** These presentations will raise awareness of suicide and help students understand the warning signs of suicide. They will also explain how to get help for themselves or their friends. These will focus on increasing "help seeking" behavior and "help giving" behavior as it relates to suicide prevention.
2. **Teacher training:** This will provide faculty and other staff with information about depression and suicide, including warning signs; differentiates "normal" adolescent behavior from at risk behavior; identifies basic intervention strategies; and reinforces a school's crisis response policies and procedures.
3. **Parent education:** This will offer presentations to parents and guardians on childhood depression, suicide, and community crisis resources. This will also cover tips on how to talk to young people about depression and suicide, as well as how to assist parents in helping their youth deal with stress and depression.

4. **Assist schools in developing suicide prevention/intervention policies and procedures:** Many schools have no policies or procedures to respond

to deal with suicide. This aspect will help school leadership establish a suicide prevention strategy, to assist staff in identifying students at risk for self-destructive/pre suicide behaviors and to respond to a suicide crisis if needed. This includes training front line staff such as teachers, nursing staff, coaches and counselors the skills and appropriate steps for intervening with students at risk, engaging families and outside support systems and community resources.

◊ *D. Target Population*

The target populations are King County school students, including alternative schools students, age 12-19 years, school staff and administrators, and the students' parents and guardians.

◊ *E. Program Goals*

- Support parents and guardians to increase knowledge and skills of suicide prevention and intervention strategies.
- Assist schools in developing suicide prevention, suicide intervention and crisis response strategies.

◊ *F. Outputs/Outcomes*

Individuals to be reached

- 3000 students
- 1500 parents
- 500 school staff

The expected outcomes include increased awareness among youth, school personnel, and parents regarding suicide, and a reduction in youth suicides in King County.

2. Funding Resources Needed and Spending Plan

The program needs $200,000 of MIDD funds per year to be sustainable.

Dates	Activity	Funding
March – July 2008	Develop scope of work and outcomes in conjunction with Crisis Clinic Teen	

	Link and YSPP	0
August 2008	Develop exhibit and written contract	0
October 15, 2008	Contract effective date	0
October – December 2008	New staff hired and trained; services commence	$ 75,000
	Total Funds 2008	**$ 75,000**
January – December 2009		$ 200,000
	Total Funds 2009	**$ 200,000**
Ongoing Annual	**Total Funds**	**$ 200,000**

3. Provider Resources Needed (number and specialty/type)

◊ *A. Number and type of providers (and where possible FTE capacity added via this strategy):*

2 FTEs to provide Suicide Awareness training and instruction, 0.75 FTE for parent and teacher training, and 0.25 for school policy development.

This strategy involves one primary provider that will utilize the 3 FTE. We will negotiate with a provider that we already have a contract with to provide this service.

◊ *B. Staff Resource Development Plan and Timeline (e.g. training needs, etc.)*

Existing provider staff are trained and seen as experts on youth depression and suicide, however all of the newly hired staff will require training. A coordinated effort between these agencies is central to the strategy to ensure there is a systematic approach to the implementation of the suicide prevention strategy in schools, and/or school districts (depending on the local need).

◊ *C. Partnership/Linkages*

This strategy will involve a partnership between schools, school districts, Public Health, mental health providers serving children of active duty military personnel, and other King County youth serving agencies.

4. Implementation/Timelines

◊ A. *Project Planning and Overall Implementation Timeline*

March 2008 through July 2008: develop scope of work and contract.

◊ *B. Procurement of Providers*

August 2008: King County already contracts with the Crisis Clinic for Teen Link services so MHCADSD will amend this contract to add funding and an exhibit for the

additional work and outcomes, including the subcontract for the additional work and hiring of FTEs.

◊ *D. Contracting of Services*

September 15, 2008 effective date

◊ *E. Services Start Date*

October 2008 services provided to youth, parents and schools.

25 -- Working Title of Concept: School Based Support Services

Name of Person Submitting Concept: Barbara Luniuck-Rakita
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Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
Concepts must be submitted via email to MIDDconcept@kingcounty.gov by ***October 31, 2015****.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

The school based support service proposed for King County is a half time MIDD counselor in each middle school. This MIDD counselor would be a licensed MH licensed counselor, and would work closely with each school administration. They would be able to work with the more challenging issues that students have, or have the ability to refer the student and family for more intensive services. In almost all schools, the ratio of counselors to students is one counselor to more than a hundred students. Along with school activities and planning, these counselors do not thave the ability to respond to each student. A MIDD counselor would have additional time to meet with students, use a brief intervention when appropriate, and refer to community resources when warranted. They would be able to work with many students, those needing a brief intervention or problem solving, those students needing more on-going support, and those students and families who would be best served by outside community resources. Many community members have needs, but have no idea where to get help. For those families who have middle school students, there would be a low barrier intervention for many different needs.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

Many community members have needs, but do not know where to get help. A MIDD counselor in each middle school would be part of a network to help students in schools, as well as provide families with information about community resources. Middle school students are often reluctant to take advantage of outside help. The MIDD program is low barrier; there is no cost to participants, there are no transportation issues, as services are provided in the school, the program is confidential, and many times even reluctant students are willing to give it a try. It provides King County students with the opportunity to address issues with a problem solving approach. Too often we see students who think there is no way around their issues, who end up saying at the end of a brief intervention how much better they feel, and that they are hopeful about applying this approach to other issues as they come up. Students also have the opportunity to set and reach personal goals. With the help of a skilled counselor, and the small, easily identifiable steps to reaching goals, students can become empowered with this approach.

3. How would your concept address the need?
Please be specific.

A half time MIDD counselor in each school would not only help individual students to receive support during times of crisis, but it would also be the first step in the awareness that there are helpful, effective problem solving techniques. This knowledge would help each student in the present, but it would also lay a foundation for the future in a more positive, problem solving approach. When students learn there are

ways to address problems without taking drugs, or risk taking behaviors, they are more likely to use this approach through out their lives. The goals of addressing mental health needs before they beome overwhelming, and a mind set of less dependence on drugs are positive outcomes.

4. Who would benefit? Please describe potential program participants.

The program participants would be middle school students, but the program could be structured to include knowledge of community resources for all family members, along with collaborations with community groups to reach students and families.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

The results of a successful implementation of school based support services would be better school adjustment, commitment and grades for students. It could also include referrals to community resources for these students and their families. Yes, this data is collected for "Check & Connect" programs in schools, as well as for MIDD 4c student recipients. Data is collected for MIDD 4c in a qualitative narrative about individual students, and the impact of services on families and the schools. Narratives are sent to King County on a monthly basis with this information. Assessments are used to determine risk factors that students face at the beginning of services, and again at the end to see if there is an improvement in their outlook. School administrations are always telling our MIDD 4c counselors how grateful they are for their services in the school. Another measure used to determine success is a retroactive pre and post survey given to teachers who have students in their classes referred for services. They often see an improvement in many areas of school success.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☒ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☐ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☒ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

A MIDD counselor in each middle school would help to identify those students and families struggling with mental health, substance abuse or other issues, and become a low barrier way for these students to become more successful in their own lives, and in their school environment. The positive outcome of these interactions would hopefully give families, as well as students, a more positive way to view community resources, and become more engaged with their communities.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

It would be necessary to have mental health and substance abuse agencies work closely with schools to implement these services. All partners should be at the table to develop the plan of what this would look like, and how to implement it in the schools. A collaboration with community resources would be helpful

to maximize the potential for students and families to receive the support they need. Also, with better collaboration, services can be delivered in a more seamless way.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: $ 30,000 per year, serving – one school - 20 – 35 people per year
Partial Implementation: $ 120,000 per year, serving – four schools – 80 - 140 people per year
Full Implementation: $ 3,450,000 per year, serving –all middle schools - 4025 people per year

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.

29 --Working Title of Concept: Check and Connect

Name of Person Submitting Concept: Terry Pottmeyer
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Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
Concepts must be submitted via email to MIDDconcept@kingcounty.gov by ***October 31, 2015****.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Check and Connect
Check & Connect is a comprehensive prevention program that is designed to enhance student engagement at school and with learning for marginalized, disengaged students in grades K-12, through relationship building, problem solving and capacity building, and persistence. A goal of Check & Connect is to foster school completion with academic, emotional and social competence. The program pairs struggling middle school students who are at risk for mental health and substance abuse issues with a counselors who helps aid the student to increase skills in problem-solving, behavioral health and academic success. Building these skills are essential in the prevention for substance abuse and metal illness for King County youth.

In Check & Connect, the "Check" component refers to the process where mentors systematically monitor student performance variables (e.g., absences, tardies, behavioral referrals, grades), while the "Connect" component refers to mentors providing personalized, timely interventions to help students solve problems, build skills, and enhance competence. Mentors work with caseloads of students and families throughout the school year, functioning as liaisons between home and school and striving to build constructive family-school relationships.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

For many children, the transition into middle school is difficult, and some lack the skills they need to be successful in school. Check & Connect is a model of sustained intervention for promoting students' engagement at school and with learning. According to the "What Works Clearinghouse," Check & Connect is the only dropout prevention intervention found to have positive effects on staying in school. The program identifies children needing additional assistance, and provides them with individualized academic and social support to help them stay on track. The program pairs struggling middle school students with an adult advocate who helps them set goals, improve organizational skills and learn problem-solving techniques to help them achieve their best potential. Some students require academic help, while others benefit from being connected with activities that increase their engagement with school.

3. How would your concept address the need?
Please be specific.

Check & Connect Advocates coach students in the classroom and afterschool to develop key social and study skills in five focus areas: Commitment and motivation in school, organization, problem solving and

coping, social skills and self esteem, and conflict resolution.
Check & Connect is offered as a free service to students and families. For those families who may benefit from additional support, Check & Connect Advocates provide referrals to community services. Many Check & Connect students have stabilized or increased their grade point averages. Most of the students appreciated having another caring adult to talk to.

4. Who would benefit? Please describe potential program participants.

Youth who would benefit from this program are generally 11-14 years old and in middle school. However, the curriculum is designed to work for students K-12. These youth are in need of social, academic and organizational assistance to stay engaged and successful in school.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

The measurable outcomes that a successful Check and Connect program would achieve are; increased attendance, increase in GPA, increase in school activities, increase in student participation and motivation in the classroom, decrease in truancy, decrease in tardiness, decrease in behavioral referrals. These outcomes are measured with the school's database as well as surveys done by the youth and the teachers at the beginning and at the end of the school year.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☒ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☐ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☐ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☐ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

Check & Connect seeks to foster student engagement at school and enhances social and behavioral health. In Check & Connect, engagement is defined as commitment to and investment in learning, as well as identification with and belonging at school. Engagement is associated with desired academic, behavioral, cognitive, and affective outcomes, such as persisting in school and graduating. This clearly fits within the MIDD II objective by strengthening social, emotional, familial and academic ties for youth who may be at risk of mental illness or substance abuse.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

The Check and Connect Advocates/providers are trained mental health or substance abuse counselors with a Bachelor's or Master's degree, under the supervision of a Youth and Family Services program. In addition, a partnership with the school district is necessary. The Check and Connect providers would work within the school setting to reach the youth where they are at.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation:	**$ 50,000 per year, serving 55 people per year**
Partial Implementation:	**$ 500,000 per year, serving 525 people per year**
Full Implementation:	**$ 1,000,000 per year, serving 1050 people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.

42 -- Working Title of Concept: Student Assistance for Trauma Informed Schools

Name of Person Submitting Concept: Kimberly Beeson
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Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
Concepts must be submitted via email to MIDDconcept@kingcounty.gov by ***October 31, 2015****.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Student Assistance Programs represent a comprehensive model for the delivery of K-12 prevention, intervention, and support services. Student Assistance services are designed to reduce student risk factors, promote protective factors and increase asset development in a manner that supports youth mental health and prevents/interrupts the cycle of substance abuse. Schools have the opportunity to increase their objective for student success by becoming Whole Child (ACSD Compact) focused and trauma informed, build in systems to support compassion as a part of their learning environment, and assure steps are taken to address student health and basic needs are met. This program proposes a Mental Health and/or Certified Chemical Dependency Counselor certified Student Assistance Professional work within the school environment to address mental health related student and family needs, and in coordination with the school's overall system of support. Site selection is based on a needs assessment of the demographics, strengths and challenges, and readiness to benefit analysis, and specific intervention strategies are selected to align with individual needs of the school so as best to address the academic and social challenges of its student population.
Recommended minimum levels of service regardless of school size is two days per week. Districts or schools select from a menu of services such as training, consultation, professional development, technical assistance, core team, regional network, on-call for emergency screening and/or referral assistance, alignment with cultural competency specific approaches and skills development, and policy/procedural consultation. Training is a required component; the type of training is based on need and includes trauma informed teaching, ACEs awareness and approach, use of the Race Equity tool for addressing institutional racism in school structure, policy and practices, systems for identification referral and ongoing support, and specific skills and curricula development. Examples of these include Mental Health First Aid, Suicide Prevention/Intervention/Post Vention, Flight Response team post traumatic events, Check and Connect, Restorative Justice, and Compassionate Schools, and PBIS.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

Mental health problems affect 20% of our population, about half demonstrate signs and symptoms by the time they are 14 years old, and very few students have access to help. Schools are in the prime position to be first responders and early interveners. The earlier the problem is identified and intervened with, the better the prospects of living a healthy functioning life. As a component of this concern, substance use continues to be a significant problem among King County youth. Of those King County students in grade 10 who participated in the 2014 Washington State Healthy Youth Survey (Washington State Department of

Health et al., 2014), at some time in their lives:

- **31% felt depressed**
- **18% had considered suicide within the past year**
- **14% made a suicide plan**
- **9% attempted suicide**
- **61.5% had tried alcohol**
- **26% had tried marijuana**
- **12% self identify as problem alcohol drinkers**
- **17% have driven a car after using marijuana**
- **14% report not feeling safe at school**
- **5% report carrying a weapon to school**

Each year suicide attempts and completions are addressed in multiple schools. Eight King County youth suicides occurred in 2015, with perhaps 17 times that number more attempts. In each instance, the students left behind are in need of a safe supportive school to reengage with as a part of their grief and learning process. Mental health services are a critical component to creating a safe, supportive and healthy school climate for traumatized students to reengage in learning and receive proper support.

These findings underscore the enduring need for services to help youth make positive decisions regarding the use of alcohol and other drugs in order to in order to successfully engage in their education, their health and their preparation for adulthood.

Schools can and must address the mental health of their employees, students and communities. Student Assistance and the Compassionate Schools model enables this emphasis with needed resources and skills that align the goals of student success, school safety and equity at the center of its work.

3. How would your concept address the need?
Please be specific.

The following National Student Assistance Association components are recommended as the minimum requirements needed to reduce barriers to learning and ensure student success in safe, disciplined and drug-free schools and communities:

School Board Policy
To define the school's role in creating a safe, disciplined and drug-free learning community and to clarify the relationship between student academic performance and the use of alcohol, other drugs, violence and high-risk behavior.

Staff Development
To provide all school employees with the necessary foundation of attitudes and skills to reduce risks, increase protective factors and foster resilience through Student Assistance Programs services.

Program Awareness
To educate parents, students, agencies, and the community about the school policy on alcohol, tobacco, other drugs, disruptive behavior and violence and provide information about Student Assistance services that promote resilience and student success.

Internal Referral Process
To identify and refer students with academic and social concerns to a multidisciplinary problem solving and

case management team. Identification of students will include those who show up on the Early Warning System for attendance issues, those who's behavior signals staff to express concern and make a referral, and those who self identify.

Problem Solving Team and Case Management
To evaluate how the school can best serve students with academic or social problems through solution-focused strategies.

Student Assistance Program Evaluation
To ensure continuous quality improvement of student assistance services and outcomes.

Educational Student Support Groups
To provide information, support and problem solving skills to students who are experiencing academic or social problems.

Cooperation and Collaboration with Community Agencies and Resources
To build bridges between schools, parents and community resources through referral and shared case management.

Integration with Other School-Based Programs
To integrate student assistance services with other school-based programs designed to increase resilience, improve academic performance and reduce student risk for alcohol, tobacco, other drugs and violence.

Direct Service Delivery: A full-time Chemical Dependency Professional/Prevention Specialist is specifically assigned to an individual school. Recommended minimum levels of service regardless of school size is two days per week. Services begin with the GAIN SS to serve as a triage for service delivery and case management. Students are referred to individual and educational support group counseling services, inclusive of CBITS, Why Try, Check N Connect, Motivational Interviewing, and METCBT 5 as core components of service delivery while on school. External mental health and substance abuse services are recommended, case management includes meeting with families and students to encourage appropriate recommnedations, coordination with referring agencies is ongoing to ensure effective collaboration, support, and advocacy of student needs. Teachers and other school based adults are consulted with to increase effectiveness in working with students in trauma. PSESD is dedicated to assuring staff and programs function through a lens of equity and connections that respect cultural, ethnic, language and whole child contstructs.

4. Who would benefit? Please describe potential program participants.

Students experiencing trauma, youth with multiple ACEs, who are engaged in substance abuse, who are living with family members who are mentally ill or chemically dependent, who have suicide ideation, who have open CPS cases, who are disengaged with school, who experience with school is that of being disenfranchised and/or non supportive. It is estimated that two thirds or greater of the students in any given King County are impacted by trauma or chronic stress: this comprises the pool of early intervention program services. Student Assistance Counselors are expected to hold between 70 and 100 students on their case load per FTE per school year.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

Decreased substance abuse, increased delay of onset of substance abuse, decreased suicide attempts, increased sense of safety and stability within the school environment. Importantly, RMC data for student assistance, GAIN SS pre and post measurements, and HYS would be actively used for evaluation purposes.

- **Number of students who report "made a suicide plan" drops to 8% or below**
- **Number of students who report "attempted suicide" drops to 5% or below**
- **Number of students who report "had tried alcohol" drops to under 20%**
- **Number of students who report "had tried marijuana" drops below 20% within three years of program delivery**
- **Number of students who report "report not feeling safe at school" drops to 10% within two years of program delivery.**

IMPORTANT NOTE: Response to #6 below: Emphasis of Student Assistance Services is Prevention/Early Intervention with some Crisis Diversion and some System Improvements

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☐ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☐ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☐ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

The concept provided is to enable the school system to increase its degree of social and emotional support through trauma sensitive approaches through skilled staff; it will increase staff's ability to recognize signs and symptoms of distress, to understand the distinction of grief and trauma, and to accommodate teaching and support strategies to the needs of all students with a lens of culturally informed and trauma informed care. The concept is further designed to assure highly qualified staff to provide screening and interventions on campus to all students and support families under chronic stress. The result of these components will be to increase healthy coping behaviors among those experiencing distress, and thereby increasing the health of those typically and historically disenfranchised or marginalized in the educational setting – or invisible to access of help and support. This approach holds cultural equity and social justice at the forefront of its operating principles.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

Student Assistance is inter-dependent on local community based youth and family service coordination and on school readiness and engagement of ESA, administrative staff, and attendance/truancy focused staff.

9. If you are able to provide estimate(s), <u>how much funding per year</u> do you think would be necessary to implement this concept, and <u>how many people would be served</u>?

Pilot/Small-Scale Implementation: **$ 85,000 per year, serving 100 people per year**
Partial Implementation: **$ per year, serving** # of people here **people per year**
Full Implementation: **$ per year, serving** # of people here **people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.

77 -- Working Title of Concept: School-based mental health care coordination

Name of Person Submitting Concept: Jennifer DeYoung
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Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

This proposed concept seeks to improve the reach, quality, and coordination of King County school-based mental health and substance use services to achieve improved outcomes for youth.

Existing MIDD strategy 4c funds 10 local mental health and substance use treatment agencies to provide prevention, early intervention, and SBIRT in 21 schools in 11 districts. Strategy outcomes are measured primarily by number of students receiving individual services. Evaluators looked at Healthy Youth Survey data but did not find consistent impacts.

The proposed concept would strengthen and expand the current MIDD 4c strategy as follows:

-Shift to outcomes-based treatment, including universal screening, routine progress monitoring using standardized assessment tools, and assessment/reporting of measurable clinical impacts of service.
-Emphasize shared care planning and improved release of information between CMHCs, SBHCs (if applicable), and appropriate school staff.
-Rather than funding full FTE, fund the difference in cost between billable encounters and the cost of a full FTE, i.e. leverage patient-generated revenue sources to fund more school-based providers (similar to SBHC model).
-Use performance-based contracting to drive quality improvement and focus on outcomes (similar to MHIP model)
-Broaden provider roles to include care coordination in order to leverage additional community resources beyond the MIDD-funded FTE, with an emphasis on managing school-originated referrals and bi-directional information flow to appropriate school staff.
-Improve integration with schools by funding care coordinators either employed by CMHCs or school-employed social workers (potentially with school funding match). Care coordination activities will work to more effectively bring existing community resources into schools in a coordinated, efficient and effective manner, bridging the gaps that impede effective school-based care delivery and improving access to care for more youth.

2. What community <u>need, problem, or opportunity</u> does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

Inadequate access to care for mentally ill children and their families is a persistent problem. 27% of King County youth attending public schools in the 8th,10th and 12th grades report depressive feelings, and approximately 20 percent of children and adolescents suffer from

mental health problems that result in mild functional impairments. Yet we know from national data that less than 50 percent of children and adolescents with a mental illness receive adequate (or any) services, especially children with minority status. The stigma associated with a mental health issue deters many families from seeking care in the community, as do more general access issues such as transportation, convenience of hours for working parents, the need for regularly occurring appointments, and a lack of culturally-relevant care. These access issues are even more severe for youth seeking confidential services without parental involvement. Children from low-income families are especially vulnerable given that they are more likely to have mental health problems than their peers and less likely to have access to high-quality services.

Nationally, of those children and youth who do receive mental health services, the majority are being served within the public school setting . Currently, about 75 percent of children receiving mental health services receive them in schools. And for good reason: schools are where the children are located for the majority of their waking hours. Parents trust school staff, and school-based services overcome the stigma and access challenges of community-based care. School staff are often the front line in case detection, generating referrals based on observations of student behavior, school performance, and intimate knowledge of family circumstances. School-based services provide families and youth with increased opportunities to access treatment services and the ability to access them earlier.

More and more schools are seeing the importance of offering some form of behavioral health care on site. In King County, we are fortunate to have 32 school-based health centers providing on-site services, however 26 of these are located in Seattle, supported by FEL funds. Other schools in King County cobble together resources from already stretched school budgets and services from community partners such as community mental health centers (CMHCs), some of whom are willing to come on site to provide care. But even when resources are ample, it is often challenging for schools and partner agencies to work effectively together. School staff are often confused about which partner agency is the right fit for a given referral, as service mix (mental health vs. substance abuse) and funding requirements (private insurance vs. Medicaid vs. uninsured) vary widely. When schools require students to receive drug/alcohol assessments as part of disciplinary action, it can take days for agencies to respond, leaving students suspended for longer than is necessary. Schools are also frustrated by the lack of mutual information flow, as mental health providers rarely take the step of getting a release of information to share treatment progress back with the school. Thus schools make referrals and in many cases don't ever find out whether the student ended up receiving care. Additionally, community providers rarely focus on the outcomes that matter most to schools: attendance and passing classes. Meanwhile, the increasing unmet mental health needs of youth cause teachers and other school staff to feel unprepared, overwhelmed, and helpless as school and classroom learning conditions are compromised.

From the community agency side, schools can be difficult to communicate with as there is rarely one point person managing student referrals, so even if release has been obtained it is often unclear with whom information should be shared. Also, for agencies that come to schools for student appointments, there are frequently challenges finding consistent, confidential spaces to serve students, as well as difficulties sending passes and finding students who have appointments. Often, youth will receive services from multiple agencies who do not share information or coordinate care with each other. Community agencies frequently have resources to share, such as group services, trainings for school staff, and presentations for students, but have a hard time plugging in to schools and accurately assessing school needs and gaps.

From a quality perspective, although significant gains have been made over the past 40 years in the identification of evidence-based practices for youth mental health problems (Weisz & Kazdin, 2010), there is increasing acknowledgment that clinicians working in community settings are unlikely to use those practices routinely in the care they provide to youth and families (Garland et al., 2010; Becker, Smith, & Jensen-Doss, 2013). A growing body of research has supported the role of standardized assessment (SA) and outcome monitoring in improving the effectiveness of services for youth (Bickman et al. 2011). Reviews have indicated that SA is especially useful for identifying client deterioration or therapy non-response (e.g., Carlier et al. 2012; Lambert et al. 2003) and that many consumers value routine outcome measurement in the services they receive (Guthrie et al. 2008). Although clinicians report valuing SA information (Bickman et al. 2000), routine collection of this information is uncommon in community-based service delivery (Garland et al. 2003). Given their established clinical utility, increased use of SA tools has been identified as a key quality improvement target (Lyon et al. 2015; Scott and Lewis 2015). Quality improvement in behavioral health is especially timely given the shifting trend toward outcomes-based payment structures.

In summary, there is a significant unmet mental care need for King County youth. Schools are the optimal locale for providing services that can overcome care access barriers. Yet schools are often ill-equipped to collaborate and coordinate effectively with community mental health providers. In turn, community mental health providers can also improve both their coordination with schools as well as the quality of the services they provide. Aditionally, shared care plans are needed to coordinate care across providers. By creating more effective partnerships among school-based service providers, the child mental health system will be better able to coordinate services that meet families' needs. Well coordinated services lead to improved outcomes and help prevent the duplication of services. Systemic changes must weave school owned resources and community owned resources together to develop comprehensive, multifaceted, and integrated approaches for addressing barriers to learning, enhancing healthy development, and preventing morbidity and mortality from mental health and substance use disorders.

3. How would your concept address the need?
Please be specific.

Propsed strategy would improve access to care by increasing # of KC schools with school-based behavioral health services; improve quality of care by ensuring services provided use evidence-based practice; and improve coordination of care by dedicating resources to support information sharing and collaboration between providers and schools. Together these efforts would lead to improved outcomes for more children.

4. Who would benefit? Please describe potential program participants.

King County middle and high school students attending selected public schools

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

% of youth screened + for behavioral health issues who received 6+ sessions of treatment
% of youth receiving 6+ sessions who had clinically significant improvement in mental health symptoms as measured by standardized assessment tool
% of students referred for substance use assessment who were suspended for <=2 days
% of students receiving service who missed <10 days of school

% of student receiving service who got C or better in core courses

This data is currently collected for Seattle school-based health center mental health providers (in collaboration with Seattle Public Schools for academic data.)

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☒ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☐ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☐ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

The earliest identification of youth with mental health or substance use issues often occurs within school settings. This strategy would provide early intervention for King County youth at risk of or living with mental health and/or substance use disorders in the setting that is most accessible for families and most likely to reach marginalized communities.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

Mental health and substance use providers and schools

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation:	**$** # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation:	**$** # of dollars here **per year, serving** # of people here **people per year**
Full Implementation:	**$ 1,400,000 per year, serving 3000 people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.

90 -- Working Title of Concept: Expanded Prevention & Early Intervention Services for At Risk Children & Youth

Name of Person Submitting Concept: Alyssa Pyke
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Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

This concept expands Prevention and Early Intervention for At Risk Youth, including both middle and elementary school age students. The rationale for a dual focused target population is embedded in the best practices of prevention and early intervention. We propose addressing the age and developmentally appropriate social, emotional, academic, and mental health needs of the child. Through population-based and systemic strategies we can have the greatest impact and achieve the best outcomes for at risk children and youth. We believe investing in these activities at the elementary and middle school age level is the most efficient and cost-effective strategy for reaching the greatest number of high risk children and youth and preventing emotional disorders, mental illness, and chemical dependency later in life.

I. Middle School Program Services: Utilize a role similar in scope to the Mental Health Therapist/Prevention Specialist of the MIDD 4c strategy

A. Rationale: Based on lessons learned from 5 years providing these services in Seattle middle schools and operating a network of School-based Health Centers offering comprehensive medical, mental health and dental services, the current MIDD 4c scope of services should be expanded throughout the continuum of care to include:

i. Increased focus on prevention using existing tools, interventions, systems, and processes in the school building to promote mental health and physical health among the population (school-wide);

ii. Adapted services for each school that change from year to year, based on the school's need and other resources available to meet the identified needs.

B. The outcome is coordinated care which makes the most robust use of all available resources in the school.

II. Elementary School Program Services: Utilize a role similar in scope to the Mental Health Therapist/Prevention Specialist of the MIDD 4c strategy

A. Rationale: The focus on elementary school age children provides earlier engagement in prevention services; it promotes positive outcomes at a crucial time of development. The scope of services are similar to the middle schools and include:

i. A focus on prevention using existing tools, interventions, systems, and processes in the school building to promote mental health and physical health among the population (school-wide);

ii. Adapted services for each school that change from year to year, based on the school's need and other resources available to meet the identified needs.

B. The outcome is coordinated care which makes the most robust use of all available resources in the school.

2. What community <u>need, problem, or opportunity</u> does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

I. Middle School Program Services:

A. Need: Robust, well-integrated mental health and substance abuse prevention services are needed onsite in schools for middle school age youth;

B. An opportunity exists in the middle schools for prevention and early intervention services to:

i. Better address the full continuum of care
ii. Be better connected to the systems and support of the school
iii. Address the social determinants of health and wellness
iv. Have greater connections with families
v. Address school climate and culture and their effects on mental health

II. Elementary School Program Services:

A. Need: Resource limitations at the elementary schools result in a lack of mental health resources onsite.

B. Opportunity: Existing mental health services in elementary schools (often provided by community-based agencies) need resources to:

i. Address the full continuum of care
ii. Connect to the systems and the support of the school
iii. Address the social determinants of health and wellness
iv. Have greater connections with families
v. Address school climate and culture and their effects on mental health

3. <u>How would your concept address the need</u>?
Please be specific.

I. Middle School Program Services:

A. This concept incorporates MIDD 4c intervention elements along with a refined scope of prevention based services to promote mental health and prevent substance abuse:

i. Health education efforts: providing curricula (such as the Second Step Anti Bullying curriculum) promoting positive mental health in the classroom

ii. Involvement in extra curricular programs: working through school groups and programs such as Gay-Straight Alliances, Parent-Teacher-Student Associations, and after school resource groups to promote student and family-led efforts for increased mental health awareness

iii. Connecting to various community resources: fully utilizing the resources of the school and community through collaboration and referral to create a wraparound network of support for students struggling with mental health and substance abuse needs

B. This concept places increased focus on prevention using existing tools, interventions, systems, and processes in the school building to promote mental health and whole health among the population (school-wide) utilizing existing and emerging population-based interventions within the schools which promote positive mental health outcomes for students across the continuum of care. A practitioner would support the following kinds of school-wide, population-based interventions by coming alongside school staff (teachers, support, administrators) to promote and help sustain efforts within the building, some of which include:

i. Positive Behavior Interventions & Supports (PBIS): existing in many of the state's schools, this program creates systems to recognize and promote positive behaviors rather than relying solely on punitive strategies;

ii. Trauma-informed interventions: Social Emotion Learning programs, e.g. the Collaborative Learning for Educational Achievement and Resiliency (CLEAR) are emerging in the region to increase student and school staff awareness of the impacts of trauma on behaviors and interactions. This intervention educates staff on the basics of trauma-informed environments geared toward healing and it allows adults in the building to form a creative problem solving community by developing short- and long-term strategies to help students;

iii. Mental health crisis prevention & intervention: expanding upon existing school plans and programs, e.g. the Steering Clear of Crisis project at Madison Middle School gives students with suicidal, homicidal, or

self-harming thoughts, feelings or intent a response plan so that they can enter into the care system through structured collaboration with supportive adults in the building;

iv. Models using the Screening, Brief Intervention, Referral to Treatment (SBIRT) framework: such as the Broad Level Integrated Screen (BLIS) tool, currently utilized at Denny Middle School, includes a basic SBIRT screen (from the CRAFFT) and it also screens for key mental health, physical health, and safety factors. This provides a broad picture of who students are and what they are facing. This tool allows for a wide range of brief interventions and potential referral to treatment options;

v. Utilizing School-based Health Centers (SBHCs) as partners: SBHCs are strong and resourceful partners for these interventions, opening up much more robust levels of care and coordinated health services.

II. Elementary School Program Services:

A. This concept utilizes a Mental Health prevention and intervention practitioner (similar to the MIDD 4c role) to come alongside school staff to strengthen and sustain new and existing programs and interventions which target the school population, some of which include:

i. Positive Behavior Interventions & Supports (PBIS): Same as above;

ii. Trauma-informed interventions: Same as above;

iii. Other Social Emotional Learning Programs: Programs such as RULER (Recognizing, Understanding, Labeling, Expressing and Regulating emotions) are being implemented in many of the regions schools. RULER focuses on building the emotional intelligence of students and adults in the building, offering tools and defined methods for self-reflection and management of behaviors;

iv. Multi-Tiered Systems and Supports (MTSS): Utilized by many districts in the County, MTSS incorporates prevention and intervention services and strengthens the systems of identification and referral for at risk students by operating on a Response to Intervention method tiering students based on level of need;

v. Utilizing School-based Health Centers (SBHCs) as partners: Same as above.

B. The practitioner would promote school-wide interventions by reinforcing their central themes in group and individual counseling sessions:

i. Trauma-focused behavioral groups is one opportunity;

ii. Sharing the language of Social Emotional Learning programs in direct services is another opportunity to ensure that students are being reinforced in therapy and in the classroom.

C. The practitioner would also collaborate with the school and community resources available to create a wraparound network of support for students struggling with mental health issues and academic performance issues.

4. <u>Who would benefit</u>? Please describe potential program participants.

The following characterizes the target population of students to benefit from this concept for expanded middle and elementary school prevention and and early intervenition services:

i. High poverty
ii. High trauma
iii. High immigrant and refugee populations
iv. High ELL populations

5. <u>What would be the results of successful implementation of program</u>?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

I. Middle School Program Services: Successful concept results would include the following mental health, academic, and structural outcomes:

i. (Individual) Improved mental health and academic goal attainment for students receiving one on one and group services

* Measured by: King County MHITS database (currently in use)

ii. (Population) Improved academic performance including grades, test scores, and attendance

* Measured by: Aggregate data currently collected by Public Health

iii. (Population) Decreased health risk behaviors including substance use and self harm
* Measured by: Healthy Youth Survey, School-specific screening

iv. (Population) Improved perception of school climate and culture
* Measured by: School Climate Surveys

v. (Systemic) Improved behavioral and social emotional intervention systems
* Measured by: Number of violence and drug-related suspensions

II. Elementary School Program Services: Successful results for the concept would include the following mental health, academic, and structural outcomes:

i. (Population) Improved academic performance including grades, test scores, and attendance
* Measured by: Aggregate data currently collected by Public Health

ii. (Population) Improved perception of school climate and culture
* Measured by: School Climate Surveys (parents and students)

iii. (Systemic) Improved behavioral and social emotional intervention systems
* Measured by: number of suspensions and disciplinary actions

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☒ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.

☐ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.

☐ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.

☐ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

I. Middle School Program Services:

A. Prevention and early intervention services in middle schools seek to reduce the future burden of mental illness and substance abuse by promoting mental health and addressing early problems among high risk adolescent populations

B. Strengthening population level interventions in schools would work towards improved health and academic outcomes for all students, not just those with the highest need

C. Engaging and targeting populations with high poverty and high trauma allows the intervention to serve populations who experience and are adversely impacted by health disparities

D. Empowering and partnering with schools and their surrounding communities encourages more culturally responsive interventions and allows for increased focus on the social determinants of health

II. Elementary School Program Services:

A. Prevention and early intervention services in elementary schools would seek to reduce the future burden of mental illness and substance abuse by promoting mental health among high risk child populations

B. Strengthening population level interventions in schools would work towards improved health and academic outcomes for all students, not just those with the highest need

C. Focus on Elementary-aged children allows for services to engage in earlier prevention, and promote positive outcomes at a crucial time of development, improving outcomes for later in life

D. Engaging and targeting populations with high poverty and high trauma allows the intervention to serve populations who experience and are adversely impacted by health disparities

E. Empowering and partnering with schools and their surrounding communities encourages more culturally responsive interventions and allows for increased focus on the social determinants of health

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

For this concept's Middle and Elementary School Program Services, the following types of organizations and partnerships have important roles in this concept's success:

* Community Health Organizations (providing practitioners of services)
* Community Mental Health Agencies (providing practitioners of services)
* School Districts (continued support for school-wide programs which emphasize mental health and wellness and support for more school-wide screening and data sharing)
* Individual schools (building leadership, teachers, and support staff working alongside practitioners)
* Public Health Seattle-King County (PHSKC) and Mental Health, Chemical Abuse and Dependency Services (MHCADS) (providing support for data networks and lobbying for continued access to more academic data)
* Community Based Organizations (partnering with schools and practitioners to better meet the continuum care needs re: academic, health, and social needs for students and families)

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: $ 42,800 per school per year, serving 24 w/ direct services and 80 w/ indirect services people per year
Partial Implementation: $ 64,200 per school per year, serving 36 w/ direct services and 100 w/ indirect services people per year
Full Implementation: $ 107,000 per school per year, serving 60 w/ direct services and 200 w/ indirect services people per year

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.

New Concept Submission Form

Please review the preceding pages before completing this form.

Please be specific. Be sure to describe how the concept addresses mental health or substance abuse needs in King County. All programs funded by MIDD II must be implemented in King County.

130 -- Working Title of Concept: Suicide Safer Schools for King County

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Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
Concepts must be submitted via email to MIDDconcept@kingcounty.gov by ***October 31, 2015****.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Schools and the behavioral health professionals who serve them represent a critical point of prevention and intervention service for youth and school staff who are experiencing suicidal thoughts or who are engaging in suicide or related risk-taking behavior. However, many school staff in King County are not adequately trained for, or supported in, such work. Furthermore, most school protocols are outdated, inadequate or non-existent when it comes to working with youth experiencing mental health crisis or when responding to a suicide attempt or death by suicide. This unfortunate reality is despite the fact that in 2013 the Washington State legislature passed a law that requires Washington's public schools to do more in the prevention of suicide (HB1336). Specifically, HB1336 requires that within Washington's public schools, teachers receive basic training (one-hour) in identifying students who are at-risk for suicide, that school counselors and social workers receive more in-depth training (three hours), and that schools put into place crisis protocols and procedures to prevent suicide and to respond effectively in the aftermath of a student death by suicide.

While HB1336 is an important first step to reducing youth suicide in Washington, the law does not go far enough. What is also needed within schools is a more comprehensive, proactive approach to creating suicide safer schools - one that is prevention focused, emphasizes the importance of emotional health, reduces instances of bulling and substance abuse, enhances opportunities for mentoring and is initiated in conjunction with the enhancement of protocols for identifying and intervening with students at-risk for suicide. The focus of HB1336 is narrow, only on suicide prevention. HB1336 also offers minimal resources for training and technical assistance to schools.

The primary goal of this Suicide Safer Schools in King County MIDD proposal is to enhance the capacity of school staff and the behavioral health professionals and/or referral agencies' who work with them, so they

may all provide prevention, intervention, assessment, and referral services as well as enhanced services in postvention (after a suicide), re-entry (after suicide attempt) and recovery (school and individual based). An additional goal will be to build sustainable coalitions of school-community stakeholders who support the implementation of evidence-based interventions that promote students' social health and emotional wellbeing.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

Suicidal behavior and deaths by suicide are a major public health problem nationally and in King County. Most people are not aware suicide is the second leading cause of death in the State of Washington for youth 10-24 years of age. In our state we loose two youth to suicide each week and twice as many young people die by suicide than by homicide in Washington State. Without proper care for underlying issues such as depression, substance abuse and mental illness, many King County youth and school staff who suffer from suicidal thoughts (ideation) and suicide attempts over utilize emergency rooms and inpatient psychiatric care. These service utilizations are expensive to individuals seeking care, they are costly to King County taxpayers, and they frequently result in fractured care across systems. They also present challenges for student's successful re-entry into the school system and result in loss of academic and worker productivity. Less intensive care that that can help support students at risk and decrease the likelihood of suicide ideation and attempts includes: 1) school-based social/emotional wellness programs, 2) integrated bullying prevention initiatives and 3) substance abuse prevention programming, 4) school climate enhancement, 5) peer mentoring, 6) school based mental health wraparound services, 7) universal screening for depression and suicide, and 8) cultural awareness and sensitivity. Such a combination of services, when coupled with suicide prevention and intervention specific training for parents, students, school staff as well as enhanced protocols and linkages with referral systems represents a comprehensive approach to suicide prevention. This approach is long overdue in many schools within King County. By addressing suicidal behavior head-on in the context of treatment for behavioral health disorders and a comprehensive approach to suicide safer schools in King County, there is enormous potential to save lives lost to suicide and to improve the quality and responsiveness of behavioral healthcare systems in general. Increasingly, schools are realizing students can only succeed academically when their social and emotional needs are also met. Thus, the development of school based safety network needs to parallel academic learning initiatives. The acquisition of social emotional skills and good coping strategies not only is likely to reduce and/or prevent youth dying by suicide, but has broader implications for reducing other problems including: delinquency, alcohol and tobacco use, forms of addiction and other kinds of violence.

3. How would your concept address the need?
Please be specific.

To implement a comprehensive approach in schools across King County we propose cohorts of 10 schools (public and private) participate in a two-year program led by suicide prevention experts with experience working within school systems. By the end of 7 years 60 schools could be served if 10 new schools joined each year during years one through six. Year one of services would focus on a) expanding linkages between the schools and referral agencies, b) enhancing protocols, c) initiating parent training, d) initiating school staff training, and e) initiating student training. Year two of services would emphasize the integration of a) social and emotional learning programs, b) bullying prevention programs, c) substance abuse prevention programs, d) enhancement of school climate, e) establishing or strengthening mentoring supports, f) establishing or strengthen school based mental health wraparound services, g) universal screening for depression and suicide, and cultural awareness/sensitivity programming.

4. Who would benefit? Please describe potential program participants.

K-12 students in public and private schools within King County, their families/care-givers, teachers, and behavioral health agencies, emergency department staff, emergency medical transport services, law enforcement agencies including School Resource Officers.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

Successful implementation will be measured in terms of the number of protocols enhanced within the schools, decreased rates of self-reported student depression and suicide ideation (through the Healthy Youth Survey), decreased rates of bullying and discipline referral, pre/post training knowledge surveys, and post intervention (training) surveys at 3, 6 and 12 month intervals in terms school staff's utilization of suicide intervention training tools. Ultimately, decreased rates of suicide and hospital utilization within King County are also a goal of the project

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☒ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.

☐ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.

☐ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.

☐ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

Enhanced behavioral health systems and surveillance protocols for individuals at risk at suicide will enhance these individuals' chances for academic, economic and social success as well as reduce costs to King County in terms of hospitalization, medical services, and loss in worker productivity.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

Partnerships with schools, referral agencies, parents and police agencies that employ school resources officers (SROs), and experts in the suicide prevention field are necessary for a comprehensive approach to school based suicide prevention.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation:	**$ 42,500 per year, serving 3,750 people per year**
Partial Implementation:	**$ 85,000 per year, serving 7,500 people per year**
Full Implementation:	**$ 170,00 per year, serving 15,000 people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.